

FINANCIAL ASSISTANCE APPLICATION

Patient Name:
Address & Phone #:
Patient SSN :
Responsible Party Name:
Responsible Party SSN :

Dependents in Household – (This includes spouse, children under 18 yrs and all others claimed on your tax return)

Name: (First, Middle and Last Name, if different than patient)

Age:

Employment – Patient/Responsible Party

Employer Name: _____

Patient Occupation: _____

Length of time at current employment: _____

If unemployed, date last worked: _____

Patient's/Responsible party Gross Monthly Salary: _____

Other Income

	Patient	Spouse
Social Security		
Pension		
Unemployment		
Worker's Comp		
VA Benefits		

I, the undersigned, certify that I am eligible for financial assistance because I am the person responsible for payment of amounts that may be due because of services provided. I further certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process I understand that falsification of information or failure to complete all fields submitted may jeopardize my consideration for the program.

Applicant signature: _____

Date: _____