

Name:		Account Number:	
Address:			
City:	State:	Zip Code:	
Phone:		SSN:	

HOUSEHOLD INFORMATION: Please list all members of the household, including patient, spouse and any biological/legally adopted children under 18 years old

First and Last Name	Relationship to patient	Age/DOB	Total Gross Income in the 3 months prior to the date of service	Total Gross Income in the 12 months prior to the date of service
	Self		\$	\$
			\$	\$
			\$	\$
			\$	\$
			\$	\$

If you have no income, how are you being supported?

- Did you have health insurance on the date of service? No Yes (Provide card copy with application)
- Does anyone in your household have a checking and or savings account? No Yes (Value \$ _____)
- Does anyone in your household have any other assets? No Yes (Type/Value: \$ _____)

For **Income/Assets** listed above, you must provide the following for each member of the household:

- Employment = paystubs showing gross income for 3 or 12 months prior to the date of service
- Self Employment = Complete tax forms from most recent filing including Schedule C
- Social Security/Pension/Disability = Most recent benefit letter
- Other = Proof of any other income (unemployment benefits, dividends, interest, rental income, etc.)
- Checking/Savings = Current 30-day statement for each account

By signing this document:

I affirm all the answers on this application are true. Should a subsequent review reveal that any information provided was fraudulent, the decision to provide financial assistance may be reversed and the responsible party will be billed.

I understand that the information I submit is subject to verification and review by federal and/or state agencies and others as required.

Patient Signature: _____ Date: _____