



<b>Name:</b>		<b>Account Number:</b>	
<b>Address:</b>			
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	
<b>Phone:</b>		<b>SSN (Last 4 digits):</b>	

**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 you are 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:** \_\_\_\_\_

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