

Financial Assistance Application

Name:			Account Number:		
Address:			Account Number.		
City:		State:	Zip Code:		
Phone:			SSN (Last 4 digits):		
HOUSEHOLD INFORMATION: any biological/legally adopted c			old, including patient, spo	ouse and	
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 y	ou are being support	ed?			
Did you have health insurance of Does anyone in your household Does anyone in your household	have a checking and or	savings account?	['] □No □Yes (Value	,	
For Income/Assets listed above Employment = paystubs show Self-Employment = Complete Social Security/Pension/Disab Other = Proof of any other in Checking/Savings = Current	ving gross income for 3 tax forms from most in oility = Most recent bea come (unemployment	3 or 12 months pr recent filing includ nefit letter benefits, dividend	ior to the date of service ing Schedule C		
By signing this document: I affirm all the answers on this was fraudulent, the decision to I understand that the informatio others as required.	provide financial assis	tance may be rev	ersed and the responsib	le party will be billed.	
Patient Signature:					
Authorized Rep Signature:		Date:			