



Charity Care/Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

- Do you need an interpreter? Yes No *If Yes, list preferred language:*
- Has the patient applied for Medicaid? Yes No *May be required to apply before being considered for financial assistance*
- Does the patient receive state public services such as TANF, Basic Food, or WIC? Yes No
- Is the patient currently homeless? Yes No
- Is the patient's medical care need related to a car accident or work injury? Yes No

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name		Patient middle name		Patient last name	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify _____)		Birth Date		Social Security Number (optional*)	
Person Responsible for Paying Bill		Relationship to Patient	Birth Date	Social Security Number (optional*)	
Mailing Address				Main contact number(s)	
City		State		Zip Code	
				() _____ () _____ Email Address: _____	
Employment status of person responsible for paying bill					
<input type="checkbox"/> Employed (date of hire: _____) <input type="checkbox"/> Unemployed (how long unemployed: _____) <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other (_____)					

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____

Attach additional page if needed

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (please explain _____)