Curative Care Center
Health Care Clinic

Financial Assistance Application Form ——Confidential

Please fil 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 this patient receive state public services such as TANF, Basic Food, or WIC? ☐Yes ☐NO

Is the patient currently homeless? ☐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 INFORMATION

Patient First Name	**Patient Middle Name**		**Patient Last Name**
☐**MALE** ☐**FEMALE** ☐**OTHER** (may specify_____)	**Date of Birth**		**Social Security Number** *(optional*)*
Person Responsible for Paying Bill	**Relationship to Patient**	**Date of Birth**	**Social Security Number** *(optional*)*

Mailing Address

_____

_____

City State Zip Code

Main Contact Number(s)

CELL: _____

HOME: _____

Email Address:

_____

Employment status of person responsible for paying bill	☐ Self Employed	☐Disabled	☐ Retired
☐Unemployed (how long unemployed:_____)	☐ Student	☐Other	

FAMILY INFORMATION

List family members in your household, including yourself. "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: Employer(s) name or source of income

Patient Signature: _____ **Date Signed**: _____

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INCOME INFORMATION

REMEMBER: You must include proof of income with your application

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

EXAMPLES OF PROOF OF INCOME INCLUDE:

- A "W-2" withholding statement; or
- Current pay stubs (3 months); or
- Last year's income tax return, including schedules if applicable; or
- Written signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation

MONTHLY HOUSHOLD EXPENSES

Rent/Mortgage: $_____

Medical Expenses: $_____

Insurance Premiums: $_____

Utilities: $_____

Other Debt/Expenses: $_____

Other (child support, loans, etc.): $_____

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Curative Care Center may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and will be responsible for and expected to pay for services provided.

Patient Signature: _____ **Date Signed**: _____