



# FINANCIAL ASSISTANCE APPLICATION

Date: \_\_\_\_\_ Chart Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Guardian/Parent Name (if applicant is a minor child): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # People in Household: \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Last Insurance Coverage: \_\_\_\_\_

Annual Household Income (all sources for last 12 months): \$ \_\_\_\_\_

Client's Employer: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Is any household member disabled? \_\_\_\_ Yes \_\_\_\_ No

Are you single head of household with Children? \_\_\_\_ Yes \_\_\_\_ No

*The information below is used for statistical information only and will not be used to determine eligibility. If you have any questions of problems with this section please ask the office for assistance.*

<b>ETHNICITY:</b> _____	Hispanic or Latino not Hispanic or Latino	<b>SOCIAL SECURITY NUMBER</b> _____
<b>RACE (mark one)</b>		
<b>Single Race:</b>		<b>Multi-Race</b>
_____ White		_____ American Indian & Alaskan Native & White
_____ Black or African American		_____ Asian & White
_____ Asian		_____ Black or African American & White
_____ American Indian & Alaskan Native		_____ American Indian & Alaskan Native & Black or African American

-----Office Use Only-----

## Payment

Client's Co-pay: \$ \_\_\_\_\_ Funding Source: (Circle source to bill) SCPF SS CDBG SWB

Census Tract Indicating Residency

HUD Qualified Yes/No

Provider Assigned \_\_\_\_\_ Visit date \_\_\_\_\_ Provider Assigned \_\_\_\_\_ Visit date \_\_\_\_\_

Client's Income Verification is REQUIRED

Source of Verification: Paystubs/ Taxes/ W-2/ SWB Letter/ Other

Medicaid DCN# \_\_\_\_\_ Active/Inactive Medicaid Verification: \_\_\_\_\_

Approved by: \_\_\_\_\_ Denial

Reason: \_\_\_\_\_