Patient Financial Assistance Application

Income Verification: Please provide copies of the following documents to verify your income:

1. Copy of Medicaid denial letter (ALL pages)
2. Prior years filed income tax return
3. Prior years W-2 and/or 1099
4. Last 2 concurrent pay stubs
5. Social Security and/or pension
6. Most recent bank statement

Household Member Information:			
Please list household members below:		Number in household based on tax returns:	
1		Date of Birth:	
2		Date of Birth:	
3		Date of Birth:	
If additional lines are needed, please attach a sheet.			
Total Gross Income from all household members:		$	

Patient Information:		
Name:	Age:	Home Phone:
Address:		Alternate Phone:
		Employer:
Spouse/Parent of Minor:		Relationship:
Address (if different):		Employer:
		Contact Phone:

Monthly Gross Income			
Applicant Wages	$	Unemployment	$
Spouse Wages	$	Supplemental Income	$
Social Security Disability	$	Alimony/Child Support	$
Pension	$	Dividends/Interest	$
VA Benefits	$	Income from Real Estate	$
Public Assistance	$	Other:	$
		Total Monthly Income:	$
		If $0 income, please provide a letter of explanation	

Any additional information or comments:

I hereby certify that the information provided above is true to the best of my knowledge.

Signature:	**Date:**

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