



Patient Financial Support Application

Income Verification: Please provide copies of the following documents to verify your income:			
1. Copy of Medicaid denial letter (ALL pages)	4. Last 2 concurrent pay stubs		
2. Prior years filed income tax	5. Social security and/or pension		
3. Prior years w-2 or 1099	6. Most Recent Bank Statement		
Household Member Information:			
Please list household members below:	Number in household based on tax returns: <input style="width: 50px;" type="text"/>		
1. <input style="width: 80%;" type="text"/>	Date of Birth: <input style="width: 100px;" type="text"/>		
2. <input style="width: 80%;" type="text"/>	Date of Birth: <input style="width: 100px;" type="text"/>		
3. <input style="width: 80%;" type="text"/>	Date of Birth: <input style="width: 100px;" type="text"/>		
4. <input style="width: 80%;" type="text"/>	Date of Birth: <input style="width: 100px;" type="text"/>		
5. <input style="width: 80%;" type="text"/>	Date of Birth: <input style="width: 100px;" type="text"/>		
Total Gross Income from all household members: <input style="width: 80%;" type="text"/>			

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

Monthly Gross Income		Monthly Obligations	
Applicants Wages	\$	Mortgage/Rent	\$
Spouses Wages	\$	Electric	\$
Social Security Disability	\$	Gas	\$
Pension	\$	Water	\$
VA Benefits	\$	Phone:	\$
Public Assistance	\$	Cell Phone:	\$
Unemployment	\$	Internet	\$
Supplemental Income	\$	Cable	\$
Alimony/Child Support	\$	Auto Insurance	\$
Dividends/Interest	\$	Car Payment	\$
Income from Real Estate	\$	Other:	\$
Other:	\$	Other:	\$
If \$0 income Statement of Zero Income Form required			
Total Monthly Income:	\$	Total Obligations:	\$

Any additional information or comments:



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Assets				
Cash on Hand	\$	Stocks/Bonds	\$	
House/Property	\$	Real Estate (Other than primary)	\$	
Checking/Savings/IRA	\$	Lump Sum Payments	\$	
Motor Vehicles(s) Automobiles, Motorcycles, Campers/RV, Boats, etc				
Type	Make	Model	Year	Value

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

Signature:	Date:
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OFFICE USE ONLY			
Preliminary Determination			
<u>Accounts in Review:</u>	1.	2.	3.
	4.	5.	6.
Total Outstanding Balance:	\$		
Date submitted to Patient Accounts:			
Returned for more information:			

OFFICE USE ONLY			
Final Determination			
Patient Insured	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type of Insurance:
Monthly Income	\$		Number of Dependents:
Poverty Level %			Expected Payment %
APPROVED / DECLINED (up to \$4,999)			Reason: Per Policy 20.01.11 guidelines.
Reviewed by Pt Accts Manager	Date:		Signature:
APPROVED / DECLINED (up to \$5,000)			Reason:
Reviewed by CFO	Date:		Signature:

Notes added to Meditech	Date:
Emailed Employee Charity Group	Date: