ACCESS FAMILY CARE
Medical & Dental Clinics

APPLICATION FOR FINANCIAL ASSISTANCE

SECTION I

Name: _____ Date: _____
(First) (Middle Initial) (Last)

Social Security Number: _____ Date of birth: ____/_____/_____
(MM) (DD) (YYYY)

Marital Status: □ Single □ Married □ Divorced □ Widow Spouse name: _____

Patient name: _____ Applicant relationship to patient: _____

Federal Grant Guidelines require us to exhaust 3rd party payor sources before applying the Slide Discount Fee.

SECTION II HOUSEHOLD INFORMATION

*Please list <u>everyone living in your home</u> (including yourself) **that this income supports,** and any one whom you claim as a dependent on your federal income tax return. Non-related adults should be listed if they contribute to the household income (food/rent/utilities). Adults (except for your Spouse) listed below with zero income must provide required documentation.*

Name (first and last)	**Age**	**Relationship to Applicant**	**Source of income (wages/social security/etc.)**	**How often are you paid? (Every week; Every other week; 1 time per month; 2 times per month; Other)**
1.				
2.				
3.				
4.				
5.				

Please include income documentation for each ADULT listed above.
Total # of household members **income is supporting**: _____ (A)
Total estimated gross annual income:_____

SECTION III INSURANCE

Do you or the patient have medical/dental insurance? □ YES □ NO

If YES, please provide a copy of the front and back of your insurance card(s) to the front desk.

SECTION IV ZERO INCOME DOCUMENTATION

Notarized Letter: A letter from the person or facility where you are currently staying stating that they are providing for your basic needs (food/shelter/clothing) and that you do not currently have a source of income. The letter must be NOTARIZED, dated within the past 30 days; signed; and include the contact information (address and telephone number) of the person who wrote the letter.

Adults other than spouse (18 years or older) who live in the home and whom you claim as dependents and/or occupants are also required to provide a notarized letter stating you provide for their basic needs as stated above.

By providing this information, you are giving us permission to contact this person for verification of the zero income status. Please check with the front desk staff if you need assistance obtaining the services of a Notary.

Income verification from Family Services: If you are receiving food stamps or Temporary Assistance for Needy Families (TANF), a copy of the income verification or statement from the Family Services office will serve as proof of income.

You must provide **one** of the options listed above for Zero Income Documentation.

SECTION V APPLICANT AFFIDAVIT

I certify that the information on this application is true and accurate. I understand that it is my responsibility to complete the application and provide the required proof of income documentation in order to apply for discounted services. I understand that if I do not provide the required income documentation on my initial visit, I will be responsible for the full charges. I understand I have 30 days from my initial date of service to provide the required income documentation and receive a discount if I qualify. I understand that no discounts will be applied to accounts older than 30 days. I agree to inform Access Family Care if my financial situation changes significantly. I also understand that falsifying information or documentation on this application will result in my application being denied and any applicable discounts received under false pretenses will be revoked and I will be responsible for all charges. I understand that all applicable insurance payments must be applied to the account prior to any discounts being applied. I understand that this application and any discount that I may qualify for apply only to the patient listed on this application. Any/all additional patients would need to apply separately.

_____ _____

PRINT NAME OF APPLICANT SIGNATURE OF APPLICANT