FINANCIAL ASSISTANCE APPLICATION DOCUMENTS CHECKLIST

PATIENT NAME: _____

GUARANTOR SSN NO: XXX-XX-_____ DATE OF BIRTH:_____

To process your application for Financial Assistance, the following information is required to determine eligibility.

_____ **PROOF OF INCOME**	**Two** (2) recent pay stubs from the patient and spouse or parent/guardian. If receiving unemployment, please send proof of unemployment benefit.
_____ **NO INCOME**	If you are reporting no income, please send signed letter from person(s) that help pay daily living expenses.
_____ **PREVIOUS CALENDAR TAX RETURN**	A copy of the previous year tax return filed by the patient or parent/guardian.
_____ **BANK STATEMENT**	A copy of the most recent statement(s) from ALL bank accounts

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The following information is required if applicable:

_____ **MEDICAID APPLICATION**	A copy of a completed Medicaid application, approval, or denial letter from the Department of Health and Human Services.
_____ **OTHER**	_____
_____	Date that form must be returned by for consideration.

Upon furnishing the above noted information, your application for Financial Assistance will be reviewed for eligibility. Should you fail to provide the required documentation, your application will be denied, and your account will proceed through the normal collection process, unless your account is already on an existing payment plan. When the Financial Form process is complete, you will be contacted by mail with the approval or denial. **A FINANCIAL ASSISTANCE APPROVAL IS VALID FOR THREE (3) MONTHS.**