Patient Financial Assistance Application

Patient Name:_______________________________ Account Number(s):_________________________

Date of Birth:______________________ Social Security Number:________________________________

Address:____City:___________________________

State:_____________________ Zip code:________________

Marital Status: _____________________________________

Employer: _____________________ _________________

Address: ______________________________________

City:_________________________Phone Number:_________________Supervisor:_________________

Spouse Name:___________________________Spouse Employer:________________________________

Spouse Company Address:____________________________________

City:____________________Phone Number:_________________Supervisor:____________________

Please list all dependents that live in your household:

____

____

Is anyone handicapped living in your home:____

Please provide a copy of your latest tax return, payroll stub or copy of Social Security award letter/check

Please answer ALL of the questions to the best of your ability.

1. What is the market value of your house/trailer?____ $__________.00
2. List any vehicles you own with their market value.

   Year Make Model

   ____ ________________ ________________________________ $__________.00

   ____ ________________ ________________________________ $__________.00
3. List all of your bank account and investment balances

   Bank Account #

   ________________ ________________________________ $__________.00

   ________________ ________________________________ $__________.00
4. List any other property you own (land rental property, boat, motorcycle, camper, etc.) with its market value.

   ____ $__________.00

   ____ $__________.00

   TOTAL ASSETS (add 1 through 4) $__________.00

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5. What are the loan balances for the property listed above?

   House/Trailer: ____ $__________.00

   Vehicle(s): ____ $__________.00

   Other: ____ $__________.00

   Other: ____ $__________.00

   Other: ____ $__________.00
6. List all your medical bills with your balances after insurance has paid (list names & phone number or attach copy of the bill)

   ____ $__________.00

   ____ $__________.00

   ____ $__________.00

   ____ $__________.00

   ____ $__________.00

   ____ $__________.00

   ____ $__________.00

   TOTAL LIABILITIES (add 5 & 6) $__________.00

The information provided is correct to the best of the knowledge and belief. You are hereby authorized to contact any of the above listed employers, creditors, banks and others for the purposes of confirming my assets, debt and financial status. Any information provided on this application which is found to be materially false, or that cannot be conformed, may result in denial of this application for financial assistance.

Signature of Applicant ______________________________ Date ______________________

**************For CARTI use only**************

Assets verified Yes / No Were all required copies included? Yes / No

Liabilities verified Yes / No The adjusted gross income per application is $____________.00

Income verified Yes / No {(Assets – Liabilities) *10% + Total Annual Income}

Requester Signature: ______________________________ Date: ______________________

Patient Access Manager Signature ______________________________ Date: ______________________

AVP Signature: ______________________________ Date: ______________________

CEO Signature: ______________________________ Date: ______________________

Approved Discount %: ______________________________ Posted date: ______________________

PATIENT/PAYMENT SOURCE FINANCIAL WORKSHEET

Patient Name: ___________________________________ **Account Number:** _______________
Household Size: ___________________________________

1A Calculation of Available Income

Monthly Salary/Pension	_________ x 12 _________	
Monthly SSI/VA	_________ x 12 _________	
Income Total	_________ x 12 _________	(AA)

1B Calculation of Monthly Expenses

Rent	___________________	
Electric	___________________	
Gas	___________________	
Telephone	___________________	
Water	___________________	
Car Payments	___________________	
Credit Cards	___________________	
Insurance	___________________	
Other ______________	___________________	
Food ($100.00 x dependents)	___________________	
Monthly Expense Total	___________________	
Expense Total	___________x 12_________	(BB)

1C Eligible Income for Medical Bills ___________________ (CC)
(AA – BB) (if less then 0, enter 1)

1D Medical Billing Estimate to Patient ___________________ (DD)

1E Identification of Liquid Assets

Bank Accounts	_____________	
Bonds	_____________	
Stocks	_____________	
CD's	_____________	
Mutual Funds	_____________	
Liquid Asset Total		___________________(EE)

1F Total Patient Due Minus Liquid Assets (DD- EE) ___________________(FF)

1G Eligible Income Minus Patient Due (CC-FF) ___________________(GG)
Note: If GG is a negative number, then patient will have no financial responsibility.

_____ **I attest that the above information is correct.**

_____ **I attest that the Patient/Payment Source is unemployed and cannot provide employment documentation.**

____ ________________________
Signature of Patient/Payment Source **Date**