PALO ALTO COUNTY HEALTH SYSTEM
Financial Assistance Application

We are required by law to keep information about you confidential. The information below will only be used for the purpose of confirming your need for financial assistance. Financial assistance is based on Federal Poverty Income Levels. **Incomplete forms will not be processed. Income verification such as previous Income Tax Return or three months of paycheck stubs must be submitted for this form to be considered complete. An approval or denial from Medicaid must also be provided.** Information must be submitted for the individual applying **and** any other adults living within the same household.

Applicant:	Spouse/Significant Other:
SSN (optional*): Birth date:	SSN (optional*): Birth date:
Street Address:	City, State:
Phone/Cell Phone:	

Household Gross Monthly Income: (Include all income from Salary/Wages, Child Support, Alimony, Social Security, Veteran's Benefits, Retirement/Pensions, Workman's Comp/Unemployment, Interest Earnings, Dividends, or Other Income)

Source	Monthly Total	Source	Monthly Total
_____	_____	_____	_____
_____	_____	_____	_____

If Income is $0.00 (zero) explain:

Resources (optional*):

Checking Account Balance: $ _____

Savings Account Balance: $ _____

Investments: $_____

Other Property Values (optional*): (2nd home, boat, RV, snowmobile, etc.)

$_____ Description: _____

$_____ Description: _____

$_____ Description: _____

$_____ Description: _____

Total Number of Dependents and Adults in the household: _____

Dependents:	Name	Date of Birth	Name	Date of Birth
1.	_____	_____	3. _____	_____
2.	_____	_____	4. _____	_____

Other Adults in the Household:

	Name	Date of Birth	Name	Date of Birth
1.	_____	_____	2. _____	_____

CLIENT AFFIRMATION: I affirm that the statements made herein are true and correct to the best of my knowledge. I understand that any false statements or misstatements of material fact could result in disqualification for financial assistance. **I understand that I must provide verification of income.**

I affirm I have been a resident of Palo Alto County Health System market area for at least one year and that the preceding information is true and correct to the best of my knowledge. I understand that the information, which I submit, is subject to verification by Palo Alto County Health System.

Patient Signature: _____ Date: _____

Please return your application with:

1) Copies of last year's income tax return; and/or correspondence from employer or governmental agency, copies of bank statements, W-2 statements, or current payroll check stubs for the last three months.
2) Your approval or denial from Medicaid, or a completed Medicaid application

*Not required for sliding fee

Office Use Only

Notes:

Medicaid Decision: _____

❑ Applicant is Eligible

Percentage of Financial Assistance Granted: _____

Dollar Amount of Financial Assistance _____

Additional Assistance Amount _____

Additional Assistance Amount _____

Additional Assistance Amount _____

Additional Assistance Amount _____

Additional Assistance Amount _____

Type of Service: Attach detail w/Dates of Service

❑ Applicant is Ineligible

Reason for ineligibility: _____

Notice of determination
sent to patient _____
Date

Signed _____
Patient Financial Services Director

Signed _____
Chief Financial Officer

Income Recap

Income Tax Gross Income	$ _____
Wages	$ _____
	$ _____
Social Security	$ _____
	$ _____
Unemployment	$ _____
Child Support	$ _____
Other	$ _____
Total Income	**$** _____