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 and three months of pay stubs must be submitted for this form to be considered complete.** 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 correspondence from employer or governmental agency, copies of bank statements (optional\*),

W-2 statements, or current payroll check stubs for the last three months1. Completed Medicaid application (optional\*)

\*Not required for sliding fee |

**Office Use Only**

Notes:

# Income Recap

Income Tax

Gross Income $

Wages $

 $

Social Security $

 $

Unemployment $

Child Support $

Other $

**Total Income $**

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