



Application for Financial Assistance

Patient Name: _____ Date of Service: _____

Responsible Party: _____ Number of Family: _____

Address: _____ Apt # _____

City: _____ State _____ Zip _____

Phone _____ Cell Phone _____

ANNUAL GROSS FAMILY INCOME Must provide proof for each source of income received this year and most recent tax return. If no income, please provide a written statement explaining how you meet living expenses.

Name of Employer(s)/Source of Income	Total Gross Income
_____	\$ _____
_____	\$ _____
TOTAL	\$ _____

CASH ON HAND /LIQUID ASSETS Must provide copy of last accounting (bank) statement(s) received.

	Bank/Other Financial Institutions	Amount
Checking/Cash on Hand	_____	\$ _____
Savings	_____	\$ _____
Stocks, Bonds, CD's, Ect.	_____	\$ _____
TOTAL		\$ _____

ASSETS

Real Estate: Value\$ _____ Amt Owed \$ _____ Equity \$ _____

Automobile: Value\$ _____ Amt Owed \$ _____ Equity \$ _____

Automobile: Value\$ _____ Amt Owed \$ _____ Equity \$ _____

Other: Value\$ _____ Amt Owed \$ _____ Equity \$ _____

I certify the above information is a true and accurate listing of the income, cash, and assets of the family unit requesting financial assistance.

Signature _____ Date _____

Application will not be accepted if missing information or required documentation is not received.