

Financial Assistance Application Form

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| Name of Patient: |

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| --- | --- |
| Patient’s Date of Birth: | Patient’s Social Security Number: |

|  |  |
| --- | --- |
| Address: | Daytime Phone Number: |
| City, State, ZIP: | Cell Phone Number: |
| County: | Alternate Phone Number: |

**Requesting Services:**

**Check the services for which you are requesting financial assistance**.

June 2020: Partial Assistance  Full Assistance 

July 2020: Partial Assistance  Full Assistance

**Household Information:**

**List ALL members of your household, including dependents, who were on your most recent IRS Form 1040.**

|  |  |  |
| --- | --- | --- |
| **Names** | **Relation to Patient** | **Age** |
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**Annual Household Income:**

**Give annual income for yourself and other household members.**

**Also attach copies of your proof of income documents (W-2, pay stub).**

|  |  |  |
| --- | --- | --- |
| **Annual Gross Income** | **Self** | **Spouse and/or Other Household Members** |
| Wages/Self-employment | $ | $ |
| Social Security | $ | $ |
| Pension or Retirement income | $ | $ |
| Dividends and Interest | $ | $ |
| Rents and Royalties | $ | $ |
| Unemployment | $ | $ |
| Workers’ Compensation | $ | $ |
| Alimony and Child Support | $ | $ |
| Cash | $ | $ |
| Bank Accounts | $ | $ |
| Money Market Accounts | $ | $ |
| Other Income | $ | $ |
| **Total Annual Family Income** | **$** | **$** |

**Additional Comments:**

***Disclaimer****: I understand that the information I provide will be used only to determine financial responsibility for my charges at New Hope Therapy (NHT) and will be kept confidential. I understand that the materials I send to prove my income and assets will not be returned. I further understand that the information which I submit concerning my annual family income and family size is subject to verification by NHT including, as necessary, obtaining financial information from employers, banks, and other entities listed by me in this application. I understand that if any information I have given is determined to be false, it may result in reversing the financial assistance approval, and I will be liable for the full amount of all charges.*

*My signature authorizes NHT to verify all information provided on this form. I certify that the above information is true and accurate to the best of my knowledge.*

 **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_