



## Financial Assistance Application

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_

**Dependents:** (Provide 50% or more of their support)

Full Name	Relationship	Age	Total in Household (Including Pt.)

Monthly Source of Income	Patient/ Legal Guardian Monthly Gross Income	+	Spouse/Other Monthly Gross Income	=	Total Family Monthly Income	x12=	Annual Gross Income
Wages/Self Employment, Child Support, Alimony		+		=		x12=	
Social Security		+		=		x12=	
Pension, Dividends, Interest, Rental Income		+		=		x12=	
Unemployment, Workers' Compensation, VA Benefits		+		=		x12=	
<b>TOTAL</b>							\$

**\*Please attach proof of income. This application cannot be processed without supporting documentation.**

I have applied for or will apply for state medical assistance. Yes No

I certify that the information provided in this application is correct and true to the best of my knowledge.

\_\_\_\_\_  
Patient / Legal Representative Signature

\_\_\_\_\_  
Date