Financial Assistance Application: Rural Health Clinic

Need assistance call 970.507.3939 or 907.507.3942

Patient's Name: ____MRN#____________Date_____________

In order for a Financial Assistance request to be processed, the following information MUST be returned with this application. If you cannot provide the following please explain: (I certify that the information provided is true & complete)

- Most recent pay stubs or Supplemental Security Income (SSI provided by Social Security)
- Most recent statements from checking account
- Most recent Federal Income tax forms including schedules, C, D, E, & F
- Most recent W2 statement or 1099

Guarantor Name :_____________________________Relationship to Patient __________SS#__________________
(Head of household)

Spouse's Name if Married________________________________SS#________________Phone_________________

Street Address:____City______________State___Zip______________

How many dependents live in household? ______Please list total family members in household_________________

List Monthly Income:

Employment ________________SSI _____________Alimony/Child Support ____________Pension____________

Public Assistance ____________Rental Income______________

I certify that the information provided is true and accurate.

Signature of Applicant: ____Date________________

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Adjustment totals: _____________Adjustment Alias ___________Financial Asst. Category___________________

Approvals:
Manager ____Date__________________

Director____Date__________________

CFO____Date_________________

Percentage of FPL Guidelines is ____________________Approved if below _______________ of FPL Guidelines

Reviewed / Revised 11/16/2020

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