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Financial Assistance Application

This application must be submitted with one of the following documents:

1. Most current federal tax return
2. Most current state tax return
3. Most recent employer pay stub
4. Copy of all bank statements for the last three months

Patient information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)

Name (first and last): ____________________

Birth date: __________ **Marital status:** __________ **Phone number:** __________

Mailing address: __________ **City:** __________ **State:** ______ **ZIP:** ______

Employer: __________ **Employment status:** __________

Number of hours worked per week: __________ **Employer phone number:** __________

Insurance: ____________________

Please attach proof of application/denial for any Federal and State funded insurance programs if patient may be eligible for coverage.

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Responsible party's/legal guardian's information

☐ Same as Patient information above

(If patient above is same as responsible party, leave this section blank.)

Name (first and last): ______________________________

Birth date: __________ **Marital status:** __________ **Phone number:** __________

Mailing address: __________ **City:** __________ **State:** ______ **ZIP:** ______

Employer: __________ **Employment status:** __________

Number of hours worked per week: __________ **Employer phone number:** __________

Spouse information

(If patient is same as responsible party, fill in spouse information for patient.)

Name (first and last): ______________________________

Birth date: __________ **Marital status:** __________ **Phone number:** __________

Mailing address: __________ **City:** __________ **State:** ______ **ZIP:** ______

Employer: __________ **Employment status:** __________

Number of hours worked per week: __________ **Employer phone number:** __________

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Dependents of responsible party

Name: ____________ **Birth date:** ________ **Relationship to responsible party:** ____________

Name: ____________ **Birth date:** ________ **Relationship to responsible party:** ____________

Name: ____________ **Birth date:** ________ **Relationship to responsible party:** ____________

Name: ____________ **Birth date:** ________ **Relationship to responsible party:** ____________

Number of adults and children living in household: ____________

(Please use comments section if additional room for dependents is needed.)

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income: ____________

Applicant spouse income: ____________

Social security benefits: ____________

Pension/retirement income: ____________

Disability income: ____________

Unemployment compensation: ____________

Worker's compensation: ____________

Interest/dividend income: ____________

Child support received: ____________

Alimony received: ____________

Rental property income: ____________

Food stamps: ____________

Trust fund distribution received: ____________

Other income: ____________

Other income: ____________

Total gross monthly income: ____________

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Assets

Cash/savings/checking accounts: ______________________________

Stocks/bonds/investments/CD(s): ______________________________

Home/other real estate/secondary residence: ______________________________

Boat/RV/motorcycle/recreational vehicle: ______________________________

Automobile(s): ______________________________

Other assets: ______________________________

I hereby certify that the above information is true and complete to the best of my knowledge.

I hereby authorize Compassus to obtain information from external credit reporting agencies if Compassus deems necessary.

Signature of applicant: ______________________________

Date: ______________________________

Comments

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Please return this form and required financial documents to your local program

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