FINANCIAL ASSISTANCE ELIGIBILITY FORM

Date _____Patient Name _____Acct #_____

Does the patient, spouse, or guardian has health insurance?

	Patient		Spouse		Guardian	
	Yes	No	Yes	No	Yes	No
Medicare Primary?	___	___	___	___	___	___
Medicaid Primary?	___	___	___	___	___	___
Other Primary?	___	___	___	___	___	___
Medicare Secondary?	___	___	___	___	___	___
Medicaid Secondary?	___	___	___	___	___	___
Other Secondary?	___	___	___	___	___	___
Other Tertiary?	___	___	___	___	___	___

If you have health insurance then send a copy, front and back, of your insurance card(s).

Annual Income:

Gross Salary/Wages	$_____
Social Security	$_____
Pension Plans	$_____
Interest & Dividends	$_____
Spouse Income	$_____
Guarantor Income	$_____
Railroad Retirement	$_____
Veterans Benefits	$_____
Alimony	$_____
Unemployment	$_____
Other-Gov't assistance, etc	$_____
Total	$_____

Currently employed? ____(Y/N) Date Employment Terminated _____

Employer _____Contact Person _____Ph # _____

Number of dependents claimed on tax return? _____

I give my permission to contact my current/previous employer to verify my income.

_____ _____

Patient/Guarantor Signature Date

If we determine that the information provided by the patient was incorrect, or if the applicant has received or could receive compensation from another source, we will reverse the indigent discount and notify the patient.

Office use only:

Approved by _____ Date

Indigent Adjustment _____ Date

Declined by _____ Date

Declination letter sent by _____ Date _____