Financial Assistance Application

Patient name_____ Date_____

If patient is a minor or is unable to fill out forms(parent, guardian, or responsible party) must sign below.

Name_____Relationship to patient_____

All requested information must be returned with application to be considered

All information provided in this application will be held in strict confidence. If you have any questions please contact our billing department at 505-439-1397 or 1-866-434-7210.

Complete and sign the financial assistance form and provide:

- Proof of Total household income/expenses: In order to approve financial assistance we require copies of:
  - ___ Last year's tax return (If you did not file a tax return a letter of explanation is required.)
  - ___ Last 3 pay stubs (If currently employed)
  - ___ Last month's checking/savings account statement
  - ___ Benefit letter showing you receive additional income such as pension, SSI, child support, unemployment benefits, etc. (If benefit letter is unavailable, then copies of last 3 bank statements showing the deposits is acceptable.
  - ___ Letter of explanation of how you are meeting your daily living expenses If you are not working or receiving any support.

- Proof of non-eligibility of state medical assistance:
  - ___ A note/letter from Dept. of Human Services showing your ineligibility will suffice.

Patient Information:

Patient Name_____ Date of Birth_____
SS#_____ Telephone _____
Address_____
City_____State____Zip code_____

Married_____Divored_____Widowed_____Separated_____Single_____

If patient is a minor:
Guarantor Name_____
SS#_____ Telephone _____
Address_____
City_____State____Zip code_____

Employer_____Business Phone_____
Address_____
City_____State____Zip code_____
Supervisor name_____
Monthly Salary_____ How often paid_____

Spouse Name_____
SS#_____
Address_____
City_____State_____Zip code_____

Spouse Employer_____Business Phone_____
Address_____
City_____State_____Zip code_____
Supervisor name_____
Monthly Salary_____ How often paid_____

Dependents living at home: Relationship Date of Birth
1. _____
2. _____
3. _____

Expenses:
Rent/Mortgage $_____Paid to:_____Phone number_____
Electric_____Gas/Propane_____Water_____
Assets:
Vehicle_____Make_____Model_____
Vehicle_____Make_____Model_____
Checking Account Balance_____
Savings Account Balance_____

If you have insurance coverage and are applying for assistance with a deductible only:

Deductible is $_____
What portion could you pay per visit if your application is approved? $_____

If you have insurance coverage and are applying for assistance with a co-pay or co-insurance:

Co-pay or co-insurance is $_____
What portion could you pay per visit if your application is approved? $_____

If you have no medical insurance and are applying for total assistance:

The average charge per visit is $100. If your application is approved, what portion could you pay each visit? $_____

By signing this application you certify that the information provided is true and correct. You also understand that this information is subject to verification as we process your application. Each application is reviewed on an individual basis and processed in good faith to help those who qualify for this assistance.

Applicant's Signature_____Date_____

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Billing Dept:

Visits to date_____OOP paid to date_____

Notes:

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Administration:

Approved by: _____Date_____

Payment amount/per visit: $_____Effective date_____