AIS Healthcare

FINANCIAL SERVICES: FINANCIAL ASSISTANCE PROGRAM APPLICATION

This application must be completed and returned to AIS Healthcare with documented proof of your reported income. Sufficient documents can include tax return, paycheck stubs, unemployment or disability check stubs, Medicaid or other state-funded medical assistance forms. Updated documentation will be required each year. Please notify AIS Healthcare immediately if your financial situation or insurance status changes. Failure to notify AIS Healthcare of any changes does not protect you from your financial obligations.

Patient name: _____ Phone: _____

Address: _____

Place of employment: _____ Phone: _____

DEPENDENTS

Number of dependents: _____

Provide name and age of all dependents that rely on you for financial assistance:

Dependent name 1: _____ Age: _____

Dependent name 2: _____ Age: _____

Dependent name 3: _____ Age: _____

Dependent name 4: _____ Age: _____

FINANCIAL INFORMATION

Fill in spaces that apply. All information provided includes financial income for patient and dependents.

1. Monthly wage income (Before taxes–include wages): ..... _____

2. Monthly untaxed income (Non-taxable–include Social Security, SSI/Disability & child support): _____

3. Monthly other income (Before taxes–include pension & other income sources): ..... _____

Monthly income total: (Add lines 1, 2 & 3 for a combined total): ..... _____

ADDITIONAL INFORMATION

Any additional information to be considered with this application: _____

_____

I certify that the financial information contained in this worksheet is true and accurate and that this application is made to enable AIS Healthcare to evaluate my eligibility for future reduced, out-of-pocket medical expenses. The applicant gives consent and authorizes AIS Healthcare to make all inquiries necessary to verify information provided herein. This information includes, but is not limited to, direct contact with applicant's employers, credit holders, credit references, or financial institutions. If any of the information that I have provided proves untrue, I understand that AIS Healthcare may re-evaluate my financial status and take necessary action to collect my account.

Patient name: _____

Signature: _____ Date: _____

Advancing quality. Improving lives.