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 for the current year or the year you are requesting assistance. Sufficient documents can include:

- 1040 tax return (preferred) **or**
- Award letter, 2 monthly statements from Social Security, SSI, Disability, Pension, Retirement **or**
- (2) Two complete bank statements (all pages to include blank pages) **or**
- (2) Two recent employer paycheck stubs or unemployment check stubs **or**
- Medicaid or other state-funded medical assistance forms

All financial documents must be completed with a legible name and not be altered.

The Financial Assistance Program Application and proof of income must be renewed annually.

Patient name: _____ Cell phone: _____

Complete mailing address: _____

Email address: _____

DEPENDENTS

Provide name and age of all household members and other dependents:

Dependent name 1: _____ Age: _____

Dependent name 2: _____ Age: _____

Dependent name 3: _____ Age: _____

FINANCIAL INFORMATION

Fill in spaces that apply. All information provided includes financial income for patients and household members/dependents listed above.

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 and other income sources): ..... _____

Monthly income total: (Add lines 1, 2, and 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 reevaluate my financial status and take necessary action to collect my account.

Patient name: _____

Signature: _____ Date: _____

Advancing quality. Improving lives.