

____/____/____
(Date)

DEAR PATIENT:

Centennial Medical Group offers a variety of opportunities to assist with non-elective medical treatment, whether it be absorbing part of the cost based on need or helping to identify community or governmental programs to fit your needs. **This program does not cover elective medical services.**

If you wish to apply for financial assistance for your account, please complete the attached application and return it in the envelope provided. Your situation will be evaluated based on the national criteria for **poverty level income**. We will gladly consider you for financial assistance provided the application is completed, signed and returned with the required documents listed below within 30 days of the date of this letter.

You must continue to make payments on the account while this application is being reviewed.

REQUIRED DOCUMENTS:

- MOST RECENT COPY OF ALL INCOME FOR ONE MONTH INCLUDING PAY STUBS, SSI, PENSIONS, UNEMPLOYMENT, CHILD SUPPORT, SPOUSAL SUPPORT, ETC. IF SELF-EMPLOYED, A YEAR-TO-DATE PROFIT AND LOSS STATEMENT.
- A COPY OF YOUR MOST RECENT FEDERAL 1040 TAX RETURN (**ALL FORMS FILED** INCLUDING W-2'S AND/OR ALL SCHEDULES). CALL 1-800-829-1040 OR 1-800-829-0922 IF YOU NEED TO OBTAIN A COPY.
- IF YOU ARE RECEIVING ASSISTANCE FROM DHS, DISABILITY SERVICES, OR ANY OTHER FINANCIAL ASSISTANCE, PLEASE INCLUDE DOCUMENTATION OF YOUR CURRENT BENEFITS.

CHECKLIST

Have you answered all questions? Do not leave anything blank. Attach additional sheets if necessary.

Have you attached the following:

- | | |
|---|---|
| <input type="checkbox"/> Most recent verification of ALL income for one month (paystubs or benefit letters) | <input type="checkbox"/> Food Stamp acceptance letter |
| <input type="checkbox"/> Year to date profit and loss statement for self employed persons | <input type="checkbox"/> Statement explaining any special circumstances |
| <input type="checkbox"/> Most recent Federal tax return (all pages filed including W-2) | |

**Attachment A to Finance Policy No. 1,
Uninsured/Underinsured Patient Discounts (Charity Care)**

Financial Disclosure (Please print legibly)

Responsible Party: _____ Age: _____ Birth date: _____ SS# _____
 Spouse: _____ Age: _____ Birth date: _____ SS# _____
 Mailing Address: _____ City: _____ St: _____ Zip: _____ Phone: _____

Marital Status Single Married Legally Separated Divorced Widowed Number in household _____
 (provide copy)

Dependents (as listed on your taxes):

Name	Date of Birth	Relation	Name	Date of Birth	Relation
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Income and Financial Data

Status (employed / unemployed / student / disabled / retired)	Employer Name	Job Title	Hire Date (mm/yy)	Pay Cycle (ex: weekly, monthly)	Monthly Gross Wages
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If Unemployed:

Previous Employer	How long Unemployed	If you expect to return, when?	Unemployment Remaining	Monthly Compensation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Social Security / Disability monthly amount _____
 Pension / IRA monthly amount _____
 TANF grant monthly amount _____
 Child Support monthly amount _____
 School loans or grants _____
 Other income - list source: _____ amount _____
Total Monthly Income _____

If no income, how are you meeting your basic living needs? Basic living needs are things like food, shelter, clothing. _____

Do you currently file taxes? Yes No If not, please explain why? _____

Have you filed bankruptcy? Yes No Chapter 7 Chapter 13 Date filed: _____ Date discharged: _____

- I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
- I will apply for any and all assistance that may be available to help pay this bill.

Date: _____ **Signature of Applicant:** X _____

Date: _____ **Signature of Spouse:** X _____