ACCESS FAMILY CARE

APPLICATION FOR FINANCIAL ASSISTANCE

SECTION I

(Patient First Name) **(Middle Initial)** **(Last Name)** **Birth Date(mm/dd/yyyy)**

SECTION II HOUSEHOLD INFORMATION

Please list all dependents that this income supports.

**Adults listed below with zero income must provide required documentation (except for your spouse/domestic partner and dependents).*

Name	Age	Relationship to Applicant *(Son, daughter, friend, spouse, etc.…)*	Income Amount (*gross pay before taxes)* *(Wages, Social Security, etc.…)*	How often are you paid? *(Weekly, Bi-weekly, Monthly, Bi-Monthly)*
1		*Self*		
2				
3				
4				
5				
6				
7				

**Please include income documentation for each ADULT listed above.*

SECTION III INSURANCE

Do you have medical/dental insurance? ☐ Yes ☐ No

If YES, Please provide a copy of the front and back of your insurance card(s) to the front desk.

SECTION IV ZERO INCOME DOCUMENTATION

You must provide ONE of the options listed below for Zero income documentation:

A. Notarized Document: You can obtain a document of ZERO income from your local clinic to have notarized.

*Adults (18 years or over) other than spouse/domestic partner or dependents, who live in the home are also required to provide a notarized letter stating that you provide for their basic needs as stated above.

*By providing this information, you are giving us permission to contact this person for verification of the zero income status.

SECTION V APPLICANT AFFIDAVIT

Person completing the application? ☐ **Patient** ☐ **Parent/Guardian** ***(if the patient is a dependent, the guardian must sign)***

I certify that the information on this application is true and accurate. I understand that it is my responsibility to complete the application and provide the required proof of income documentation in order to apply for discounted services. I understand that **1.)** my self-declared income is only valid for a maximum one month, **2)** I can only self-declare once every 12 months, **3.)** I will need to bring proof of income for the sliding discount to cover any other service beyond the first month, **4.)** I have two months from my initial application date to provide the required income documentation to cover any other services beyond the first month, **5.)** this application and any discount that I may qualify for apply only to the household members listed on this application, and **6.)** falsifying information or documentation on this application will result in my application being denied and any applicable discounts received under false pretenses will be revoked and I will be responsible for all charges. I agree to inform Access Family Care if my financial situation changes significantly.

Signature **Date**

For Office Use Only

Self-Declared Sliding Fee Information	**12 Month Sliding Fee Information**
Expiration Date: Chart Number:	Starting Date: End Date:
Number of Household Members:	Number of Household Members:
Total Estimated Gross Income:	Total Gross Income:
Information entered in chart, including pop-up? Yes No	Information entered in chart, including pop-up? Yes No
Approved Sliding Fee Discount: 1 2 3 4 5 6	Approved Sliding Fee Discount: 1 2 3 4 5 6
Completed By:	Completed By: