

**PALO ALTO COUNTY HEALTH SYSTEM**  
**Financial Assistance Application**

We are required by law to keep information about you confidential. The information below will only be used for the purpose of confirming your need for financial assistance. Financial assistance is based on Federal Poverty Income Levels. **Incomplete forms will not be processed. Income verification such as previous Income Tax Return or three month's of paycheck stubs must be submitted for this form to be considered complete.** Information must be submitted for the individual applying and spouse or significant other living within the same household.

Applicant:		Spouse:	
SSN:	DOB:	SSN:	DOB:
Street Address:		City, State:	
Phone/Cell Phone:			
Household Gross Monthly Income: (Include all earned and unearned income)			
Salary/Wages \$ _____	Child Support \$ _____	Alimony \$ _____	Social Security \$ _____
Veteran's Benefits \$ _____	Retirement/Pensions \$ _____	Workman's Comp/Unemployment Benefits \$ _____	
Interest Earnings \$ _____	Dividends \$ _____		
Other Income: \$ _____	Description: _____		
<b>If Income is \$0.00 (zero) explain:</b>			
Resources:		Other Property Values: (2 <sup>nd</sup> home, boat, RV, snowmobile, etc.)	
Checking Account Balance: \$ _____		\$ _____ Description: _____	
Savings Account Balance: \$ _____		\$ _____ Description: _____	
Investments: \$ _____		\$ _____ Description: _____	
Dependents:			
	Name	Date of Birth	Name
1.	_____	_____	3. _____
2.	_____	_____	4. _____
Please indicate other financial assistance programs applied for within the last year (social security disability, Medicaid, etc.) and status (approved, denied, pending).			
<b>Title 19 Eligibility Determination:</b>			
Are you over age 21? _____			
Are you under age 65? _____			
Are you pregnant? _____			
Are you receiving social security disability? _____			
Do you have dependent children? _____			

Please provide or attach any information you feel would be helpful in understanding your current situation.

CLIENT AFFIRMATION: I affirm that the statements made herein are true and correct to the best of my knowledge. I understand that any false statements or misstatements of material fact could result in disqualification for financial assistance. **I understand that I must provide verification of income.** I understand that a credit report may be used as part of the assistance determination process.

I affirm I am a resident of Palo Alto County Health System market area and that the preceding information is true and correct to the best of my knowledge. I understand that the information, which I submit, is subject to verification by Palo Alto County Health System.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return your application with:

- 1) copies of last year's income tax return; and
- 2) your Denial from Title 19 (Department of Human Services) – if required.

If the above proof of income is not available, please verify your income by providing the following information that pertains to your situation:

- 1) Correspondence from employer or governmental agency,
- 2) Copies of bank statements,
- 3) W-2 statements, or
- 4) Current payroll check stubs for last three months.

**Office Use Only**  
 Denial from Title 19 required? \_\_\_\_\_

Applicant is Eligible  
 Dollar Amount of Financial Assistance \_\_\_\_\_

Type of Service:  
 Attach detail w/Dates of Service

Outpatient \$ \_\_\_\_\_ Inpatient \$ \_\_\_\_\_ Clinic \$ \_\_\_\_\_

Applicant is Ineligible  
 Reason for ineligibility: \_\_\_\_\_

Notice of determination sent to patient \_\_\_\_\_  
 Date \_\_\_\_\_

Signed \_\_\_\_\_  
 Director of Patient Accounts

Signed \_\_\_\_\_  
 Administrator

<b>Income Recap</b>	
Income Tax	
Gross Income	\$ _____
Wages	\$ _____
	\$ _____
Social Security	\$ _____
	\$ _____
Unemployment	\$ _____
Child Support	\$ _____
Other	\$ _____
<b>Total Income</b>	<b>\$ _____</b>