ADENA

Financial Assistance Application

Name:		Account Number:
Address:		
City:	State:	Zip Code:
Phone:		*SSN (last 4 digits):

HOUSEHOLD INFORMATION: Please list all members of the household, including patient, spouse and any biological/legally adopted children under 18 years old

First and Last Name	Relationship to patient	Age/DOB	Total Gross Income in the 3 months prior to the date of service	Total Gross Income in the 12 months prior to the date of service
	Self		$	$
			$	$
			$	$
			$	$
			$	$

If you have no income, how are you being supported?

*Did you have health insurance on the date of service? ☐ No ☐ Yes (Provide card copy with application)

*Does anyone in your household have a checking and or savings account? ☐ No ☐ Yes (Value $_____)

*Does anyone in your household have any other assets? ☐ No ☐ Yes (Type/Value: $_____)

For Income/*Assets listed above, you must provide the following for each member of the household:

☐ Employment = paystubs showing gross income for 3 or 12 months prior to the date of service
☐ Self Employment = Complete tax forms from most recent filing including Schedule C
☐ Social Security/Pension/Disability = Most recent benefit letter
☐ Other = Proof of any other income (unemployment benefits, dividends, interest, rental income, etc.)
☐ * Checking/Savings = Current 30-day statement for each account

By signing this document:

I affirm all the answers on this application are true. Should a subsequent review reveal that any information provided was fraudulent, the decision to provide financial assistance may be reversed and the responsible party will be billed.

I understand that the information I submit is subject to verification and review by federal and/or state agencies and others as required.

Patient Signature:_____Date: _____

*Optional (National Health Service Corp. is an exception, see policy for full details).

Adena Healthcare
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