BURGESS Health Center

FINANCIAL ASSISTANCE PROGRAM

Patient Name:_____ Date of Birth:_____
Responsible Party:_____ SSN:_____ Home Phone:_____
Address:_____ City:_____ State:_____ Zip:_____
Employer:_____ Work Number:_____ **Monthly Gross Income** $_____
Spouse's Name:_____ SSN:_____ **Monthly Gross Income** $_____
Employer:_____ Work Number:_____

Responsible Party's Other Income $_____ **Spouse's Other Income** $_____
Annual Gross Household Income $_____

Name & Birthday of ALL Dependents of Household:

Name_____DOB_____ Name_____DOB_____ Name_____DOB_____
Name_____DOB_____ Name_____DOB_____ Name_____DOB_____
Name_____DOB_____ Name_____DOB_____ Name_____DOB_____

PROOF OF INCOME: A COPY OF ONE OF THE FOLLOWING INFORMATION MUST ACCOMPANY YOUR APPLICATION IN ORDER TO PROCESS

___ Federal Tax Return (most recent) ___ Last 3 months of Pay Stubs (Responsible Party and Spouse) Medicaid Application: ___ In Process ___Over Income

Other Income Source Documentation:

- ❑ Social Security
- ❑ Disability
- ❑ Unemployment
- ❑ VA Assistance
- ❑ Life Insurance
- ❑ Workman's Comp.
- ❑ Railroad Retirement
- ❑ Pension
- ❑ Public Assistance
- ❑ Child Support
- ❑ Alimony
- ❑
- ❑ Savings
- ❑ Cash on Hand (Include Checking)
- ❑

I hereby acknowledge that the information, given to Burgess Health Center, is true and correct to the best of my knowledge. I authorize Burgess Health Center to verify any or all information given, and to obtain a consumer credit report to be obtained as deemed necessary. ***Must be returned within 10 business days.***

Patient/Guarantor's Signature:_____ **Date:**_____

PROOF OF INCOME REQUIRED

If you have any questions regarding this form, please contact the Financial Counselor at 712-423-9218.

Updated 06/22/2016