



**FINANCIAL ASSISTANCE PROGRAM**

Patient Name: \_\_\_\_\_  
 Responsible Party: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_  
 Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Work Number: \_\_\_\_\_ **Monthly Gross Income \$** \_\_\_\_\_  
 SSN: \_\_\_\_\_ **Monthly Gross Income \$** \_\_\_\_\_  
 Work Number: \_\_\_\_\_

**Responsible Party's Other Income \$** \_\_\_\_\_  
**Annual Gross Household Income \$** \_\_\_\_\_

**Spouse's Other 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:**

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> Social Security | <input type="checkbox"/> VA Assistance   | <input type="checkbox"/> Railroad Retirement | <input type="checkbox"/> Child Support | <input type="checkbox"/> Savings                         |
| <input type="checkbox"/> Disability      | <input type="checkbox"/> Life Insurance  | <input type="checkbox"/> Pension             | <input type="checkbox"/> Alimony       | <input type="checkbox"/> Cash on Hand (Include Checking) |
| <input type="checkbox"/> Unemployment    | <input type="checkbox"/> Workman's Comp. | <input type="checkbox"/> Public Assistance   | <input type="checkbox"/>               | <input type="checkbox"/>                                 |

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.**