ValleyHealth
Healthier, together.

Financial Assistance Application

Patient (First & Last) Name:		Patient Account Number:
Street Address:		
City:	**State:**	**Zip Code:**
Phone: (_____) _____ -_____		**Last 4 of Social Security Number:**

HOUSEHOLD INFORMATION: Please list everyone who lives in the household, including:
Yourself (if not patient), the patient, spouse (if married), and any biological/legally adopted children under 18 years old.

First and Last Name	Relationship to Patient	Date of Birth	Total Gross Income in the 3 Months Prior to the Date of Application	Total Gross Income in the 12 Months Prior to the Date of Application
	Self			

Income includes wages, Social Security, unemployment, child support, and other sources

If you have no income, how are you meeting your basic needs (Example, are you receiving help from family, friends, community programs, or other sources)?

_____

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

Does anyone in your household have a checking and/or savings account(s)? ☐ No ☐ Yes (*Total Amount*)_____

Does anyone in your household have any other assets? ☐ No ☐ Yes (*If yes, please list asset type and its estimated value. Sliding Fee Discount Program patients with incomes at or less than 200% of FPG do not have to answer or will not be assessed by asset questions.)*: _____

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 application

☐ Self-Employment = Complete tax forms from most recent filing including Schedule C

☐ Most recent tax return

☐ Social Security/Pension/Disability = Most recent benefit letter

☐ Other = Proof of any other income (unemployment benefits, dividends, interest, rental income, etc.)

☐ Checking/Savings = 3 months of complete (all pages) bank statement for each account

By signing this document:

I confirm that all the information I provided is true and complete. I understand that if any part of my application is found to be false, financial assistance may be taken back, and I may be billed for the full amount. I understand that the information I give may be checked by federal or state agencies, or other organizations as required.

Patient Signature: _____ **Date:** _____

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