STAMFORD HEALTH

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 you are 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:** _____

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