Financial Assistance & Extended Payment Plan Application

All information relating to this application will be kept confidential.

Head of Household _______________________________ Date of Birth ____________ SS# ___________________

Spouse/Partner __________________________________ Date of Birth ____________ SS# ___________________

Street Address _____________________________________City/State ____________________Zip ____________

Telephone _____________________________ Marital Status (circle one): Married Single Divorced Widowed

Employer ____ Occupation _____________________

Spouse Employer ____ Occupation _____________________

DEPENDENTS (please list first and last name):

Name ___________________________________ Relationship ______________________________ Age__________

Name ___________________________________ Relationship ______________________________ Age__________

Name ___________________________________ Relationship ______________________________ Age__________

Do you have or expect to have health insurance? Yes, start date: __________________

If NO, please explain: ____

Have you signed up for Medicaid ? Y N Received a denial letter (if yes please provide a copy) Y N

____

OFFICE USE ONLY

Patient Name:____

Date Received: ____

Date Approved:____

Approved Amount:____

- ◊ Last Years Tax Returns
- ◊ 3 months bank statements
- ◊ Other documentation to support income

Sliding Fee Discount Application

It is the policy of Broadwater Health Center to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to a Patient Assistance Specialist, to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at Broadwater Health Center, but not services or equipment that are purchased from outside, such as X-ray interpretation by a consulting radiologist and DME supplies . This form must be completed every 6 months or if your financial situation changes.

Monthly Income (proof of income is required)	
Gross Wages	$
Veteran Pension	$
Disability Pension	$
Social Security	$
Retirement (all sources)	$
Unemployment	$
Child Support/Alimony	$
Rents/Royalties	$
Workers Compensation	$
Military Allotments	$
Other ______________________	$
TOTAL	$

NOTE: Copies of tax returns from last year, 3 months pay stubs, or other information verifying income will be required before a discount is approved.

CERTIFICATION

The information provided in this application is true and correct to the best of my knowledge. Broadwater Health Center may verify any of this information. I understand additional information may be requested to qualify. False or incomplete information will result in a denied application.

______________________________________ ______________________________________

Signature: Head of Household Date Signature: Spouse Date