Financial Assistance Application

Acct #

HOPE CLINIC

Delivering hope and health

Patient Information

Last Name	First Name	Middle Name	
DOB:	SSN	Telephone Number	
Address	City	State	Zip Code
Employer Name	Employer Phone #		
Employer Address	City	State	Zip code

Spouse or Legal Guardian Information

Spouse/Guardian Last Name	First name	Middle name		
Date of Birth	SSN	telephone Number		
Address (only if different from above	City	State	Zip Code	
Employer name	Employer Telephone Number			
Employer Address	city	State	Zip code	

Section A (Income) Please provide the income for each of the following persons in your household

		(This section is only used when the patient is a minor)	
Patient Income $	Frequency: [ ]Hour [ ]Week [ ]Month [ ]Year	Father Income $	Frequency [ ]Hour [ ]Week [ ]Month [ ]Year
Spouse income $	Frequency: [ ]Hour [ ]Week [ ]Month [ ]Year	Mother Income $	Frequency [ ]Hour [ ]Week [ ]Month [ ]Year
Total Income: $		Total Income:	

Section B (Family Members) Please provide the number of people in the patient's household: #

Section C (Income Verification) Please provide ONE of the following document types to verify income. These document types are listed in order of preference

1. Paycheck Remittance
2. IRS Form W-2
3. Tax Return
4. Employer Verification
5. Social Security, Worker's Compensation or Unemployment Compensation Determination letters
6. Proof of Participation in Government Assistance
7. Bank Statements
8. Other _____

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available _____

I understand Hope Clinic of Garland, Inc. may verify the financial information contained in this Financial Assistance Application in connection with Hope Clinic of Garland, Inc.'s evaluation of this application, and by my signature hereby authorize my employer or any individual listed on this application to certify or provide additional details with respect to the information provided in this application. I also authorize Hope Clinic of Garland, Inc. to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this application may result in denial of financial assistance.

Signature of Patient or Responsible Party	Printed Name	Date
Signature of Hope Clinic Employee (Only if assisted in completion of application)	Printed Name	Date

Office Use Only

Income Verification Name of Person Contacted (1)	Date	Information Obtained
Name of Person Contacted (2)	Date	Information Obtained
Hope Clinic Employee Signature	Date	
Notes regarding number in household		
If patient/legal guardian are unable to sign the application, explain why:		

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