Financial Assistance Application

Patient Information:

Full Name: _____

Date of Birth: ____ / ____ / _____

Medicare Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Financial Information:

Current Employment Status: Employed / Unemployed / Retired (Circle One)

Monthly Income: $_____

Source(s) of Income: _____

Monthly Expenses: $_____

List Major Expenses: _____

Assets (Savings, Real Estate, etc.): _____

Number of Dependents: _____

Reason for Application:

Please describe the financial hardship you are experiencing that affects your ability to pay for Medicare costs (e.g., premiums, deductibles, co-payments). Attach additional sheets if necessary.

_____

_____

Supporting Documents:

Please attach any supporting documents that can verify your financial situation. This may include recent tax returns, pay stubs, bills, or statements from other income sources.

Declaration:

I, _____, declare that the information provided in this application is true and accurate to the best of my knowledge. I understand that providing false information may result in the denial of my application for financial hardship assistance.

Signature: _____ Date: ____ / ____ / _____

Office Use Only:

Received By: _____ Date: _____

Application Status: Approved / Denied

Notes: _____