FINANCIAL ASSISTANCE APPLICATION

As part of our commitment to ensuring access to high quality medical care to all members of our community, PLA will provide care to those in need, regardless of insurance status, ability to pay or eligibility for financial assistance under this Policy.

The need for financial assistance may be a sensitive and deeply personal issue for recipients. Confidentiality of information and preservation of individual dignity shall be maintained for all who seek financial assistance. No information obtained in the patient's application for financial assistance may be released unless the patient gives express written permission for such release, except to bona fide governmental agencies requesting aggregate data.

Available Assistance: PLA will work with patients to see if they qualify for financial assistance or an interest free low monthly payment plan. If you qualify for financial assistance, some or all charges may be discounted on a one time or recurring basis. **Please Note**: Applying for assistance does not guarantee that any assistance will be granted.

Instructions: You can submit the attached form and the requested documentation to us by mail, fax or email:

PLA, LLC
PO Box 56078
Little Rock, AR 72215
Fax: (501) 408-3439
Email: billing@plall.com

- Include this form in its entirety.
- A copy of most recent Federal Tax Return – Form 1040.
- Copies of most recent income information for each person in the household including pay stubs, Social Security, unemployment benefits, etc.
- A copy of your last 3 months bank statements.
- **All** sections must be completed for consideration of assistance. *Failure to include all the information will result in an automatic denial of any assistance.*

You should expect to receive a response from PLA regarding your application within thirty (30) days of submission. If you do not qualify for a discount, or a discount is not sufficient due to other circumstances, we will make every effort to develop a payment plan that works for you. Please call our dedicated billing team at (501) 358-3111.

By submitting this application for assistance, the patient gives Physicians' Laboratories of America consent to make necessary inquiries to confirm financial obligations, credit references or financial references.

Sincerely,

Physicians' Laboratories of America

PHYSICIANS' LABORATORIES OF AMERICA

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PATIENT INFORMATION:				
LAST NAME	**FIRST NAME**	**MI**		**SOCIAL SECURITY NUMBER**
STREET ADDRESS	**CITY**	**STATE**	**ZIP**	**TELEPHONE NUMBERS**
DOB			**MARITAL STATUS**	
EMPLOYER			**EMPLOYER PHONE NUMBER**	

INSURANCE INFORMATION: Do you have health/medical insurance coverage? [ ] Yes [ ] No *If yes, please fill out the below section. You MUST send a copy of your insurance card.			
INSURANCE NAME			**INSURANCE PHONE#**
ADDRESS	**CITY**	**STATE**	**ZIP**
POLICY HOLDER'S NAME	**POLICY HOLDER'S DOB**		**RELATIONSHIP TO PATIENT**
POLICY ID#		**POLICY GROUP #**	

HOUSEHOLD INFORMATION –LIST ALL PEOPLE LIVING IN YOUR HOUSEHOLD INCLUDING THE PATIENT.	
Number of family members living in the household	**Total Annual Gross Household Income*:**

*Total household income includes the following for all members of your household: Gross Salary, Unemployment Compensation, Disability and Worker's Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.), and Other Income.

HOUSEHOLD MEMBERS	AGE	RELATIOSHIP TO PATIENT	SOURCE OF INCOME OR EMPLOYER	MONTHLY GROSS INCOME
1.				
2.				
3.				
4.				
5.				

*Use additional paper if needed

Do you or your family members receive any of the following assistance? (Check all that apply)

Social Security Income (Disability) []
Free or Reduced School Lunch Program []
Temporary Assistance For Needy Families []
Other Public Assistance Programs [] * Specify: _____

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EXPENSES *Please attach documentation such as a copy of a payment coupon or monthly statement.	
Mortgage or Rent	**Car Payment**
Utilities	**Child Care**
Monthly Medical Expenses	

REQUIRED INFORMATION – Must be included with this application		
[] Copy of previous year's tax return	[] Copy of last 3 months bank statements	[] Income verification showing earnings or pay stubs for all income year to date

*Please do not send originals as these will not be returned. If you are self-employed, please include a copy of the last 12 months P&L statements and last year's tax return.

Additional information may be required in order to process your application, such as more detailed list of expenses or proof of assets. If so, we will contact you for this request.

If you need to write a letter explaining your individual situation, please attach it to this form.

I hereby acknowledge the above information is correct and complete to the best of my knowledge. I understand this information is subject to verification by PLA, LLC, and authorize PLA, LLC, to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation before a hardship or financial assistance discount is approved. I understand that applying for assistance is not a guarantee of approval and does not remove my obligation for these services. I understand that if I do not qualify for a hardship or financial assistance discount, I will be notified and will be responsible for my bill. I hereby acknowledge that I am neither related to, nor employed by, the physician who ordered the testing.

_____ _____

Responsible Person's Signature Date

PLA Office Use Only

Reviewed by: _____ Date: _____ Account Number: _____

% Approved: _____ Adj Amt: _____ Effective Term: _____

Denied (reason): _____

Revised 2023-11-01