

# Charity Screening Form

## WELLSPOT EAST WEST CLINIC REQUEST FOR FINANCIAL ASSISTANCE/UNCOMPENSATED SERVICES

WUXIA ACUPUNCTURE Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or under-insured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation.

To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance. Please complete the questionnaire below and return with copy(s) of your pay-check stub and bank statement.

Name \_\_\_\_\_ Guarantor/Account # \_\_\_\_\_  
 Address \_\_\_\_\_ Phone number \_\_\_\_\_  
 \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_ M=Male F=Female Do you own a home? Yes ( ) No ( )  
 Number of dependents filed on tax return: \_\_\_\_\_ Do you own other property? Yes ( ) No ( )  
 List dependents: Do you own automobiles? Yes ( ) No ( )

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Gender</u>

**INCOME: PLEASE PROVIDE PHOTOCOPIES OF PAY-CHECKS AND BANK STATEMENTS AND LIST INCOME**

	<b>Monthly</b>	<b>Annual</b>
Wages (Self)	_____	_____
(Spouse)	_____	_____
(Other Family Member)	_____	_____
Self-Employment	_____	_____
Public Assistance	_____	_____
Social Security	_____	_____
Unemployment Compensation	_____	_____
Retirement	_____	_____
Alimony /Child Support	_____	_____
Military Family Allotments	_____	_____
Pensions	_____	_____
Income from Dividends, Interest, Rent	_____	_____

**EXPENSES (Monthly)**

Mortgage/Rent (1) \_\_\_\_\_  
 Utilities \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Food \_\_\_\_\_  
 Finance/other loans \_\_\_\_\_  
 Auto Loans \_\_\_\_\_  
 Other \_\_\_\_\_  
**TOTAL EXPENSES** \_\_\_\_\_

**BANKING INFORMATION**

Checking Acct#: \_\_\_\_\_  
 Balance: \_\_\_\_\_  
 Savings Acct#: \_\_\_\_\_  
 Balance: \_\_\_\_\_

**Medical Bills**

\_\_\_\_\_

(1) If none, source of housing \_\_\_\_\_

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I agree to tell the provider of services, within 10 days, if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses, or in the persons in the household or of any change of addresses.
- I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with my employer, bank, credit verification and property searches.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the hospital from proceeds of any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by Wuxia Acupuncture or I may appeal decision in writing with additional documentation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date