Grundy Eunoia Wellness Center

Financial Assistance Application

Date_____ **Patient Name:**_____ **Date of Birth:** _____

PLEASE ATTACH COPIES OF THE FOLLOWING REQUIRED DOCUMENTATION, THEN COMPLETE AND SIGN THE APPLICATION

- ☐ Copies of 2 pay stubs for 30 Days for all income reported
- ☐ Submit a letter describing your financial situation
- ☐ Copies of unemployment statements for 30 days
- ☐ Copies of Social Security Benefits (if applicable)

Filed Federal income taxes? To request a copy of your taxes, please call 1-800-829-1040 (official transcript, no hand written forms)

- ☐ Yes – Please send the most recent Federal income tax returns and supporting schedules
- ☐ No – Please explain why:

I have applied for or will apply for federal or state medical assistance

☐ Yes (provide tracking # or denial letter) ☐ No–Not a citizen ☐ No–Over income ☐ No–Other reason, why?

OTHER MONTHLY INCOME (Please attach copies of your documents to support this income)

Other Wages		Misc. Income		Disability Income		Alimony	
Pension		Rental Income		Veterans Benefits		Unemployment	

PATIENT/RESPONSIBLE PARTY Please check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated (documentation required)

Name: (First, Middle, Last)	Social Security Number:	Birth Date: (MM/DD/YYYY)

Patient/Responsible Party Address:

Phone Number:	Employment Status:	How Often Paid:	Are you claimed on another tax return?
	☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student ☐ Retired	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	☐ Yes ☐ No If yes, provide tax return of those claiming you.

Household Size (Patient, Spouse & Dependents)	Employer Name and Address		
Hire Date: (MM/DD/YYYY)	Unemployed: (MM/DD/YYYY)	Average Gross Monthly Income:	Monthly SSI/SSDI:

SPOUSE (if applicable)

Please check one: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Legally Separated (documentation required)

Name (First, Middle, Last)	Social Security Number	Birth Date (MM/DD/YYYY)

Phone Number:	Employment Status:	How Often Paid:	Are you claimed on another tax return?
	☐ Full Time ☐ Self Employed ☐ Student ☐ Part Time ☐ Unemployed ☐ Retired	☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Bi-Monthly	☐ Yes ☐ No If yes, provide tax return of those claiming you.

Household Size: (Patient, Spouse & Dependents)	Employer Name and Address:		
Hire Date: (MM/DD/YYYY)	Unemployed: (MM/DD/YYYY)	Average Gross Monthly Income:	Monthly SSI/SSDI:

DEPENDENTS under age of 18 (If more than 3 dependents use a separate page)

Full Name	Relationship	Birth Date (MM/DD/YYYY)	Claimed as a Dependent on Taxes	
			☐ Yes	☐ No
			☐	☐
			☐	☐

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this bill. I understand that the information provided may be verified by the clinic, and I authorize the clinic to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the bill.

SIGNATURE REQUIRED IN ORDER FOR APPLICATION TO BE PROCESSED **Date**

X _____ ___/___/___