Branch Name/No: Pulmonary Associates, Inc. Patient's ID: _____

Request for Financial Assistance

The applicant must complete Sections A, B, and C, sign and date the form and return this application for company review. Bills will continue to be sent until we receive and approve the application for financial assistance.

SECTION A Financially Responsible Party's Information (Patient, Spouse, Parent, Guardian, etc.)

Date:	Responsible Party's Name: (If different than patient)
Pt. Name:	Responsible Party's SSN:
Pt. SSN:	Address:
Address:	City/State/Zip:
City/State/Zip:	Home Phone:
Home Phone:	Relationship to Patient:

Name of Insurance:	Insurance #:	Policy Holder's Name:	

SECTION B Income and Household Members

Total Income Member 1	Total Income Member 2	Total Income Member 3
$_____Salary	$_____Salary	$_____Salary
$_____SSI Benefits	$_____SSI Benefits	$_____SSI Benefits
$_____Pension	$_____Pension	$_____Pension
$_____Disability Benefits	$_____Disability Benefits	$_____Disability Benefits
$_____State Assistance	$_____State Assistance	$_____State Assistance
$_____Alimony/Child Support	$_____Alimony/Child Support	$_____Alimony/Child Support
$_____Food Stamps	$_____Food Stamps	$_____Food Stamps
$_____Rental Income	$_____Rental Income	$_____Rental Income
$_____Business Income	$_____Business Income	$_____Business Income
$_____Other Income	$_____Other Income	$_____Other Income

_____Total Household Members _____Total Household Members Over Age 18

Please list any additional information that will assist us in reviewing your request for financial assistance:
PLEASE ATTACH PROOF OF INCOME (BANK STATEMENT, PAY STUB),

[redacted]

If checked above, attach a copy, front and back, of the financially responsible party's prior year's income tax return (signed and dated)

SECTION C Beneficiary Statement

I certify that the above information is accurate to the best of my knowledge. I authorize The Company and its agents to verify the above information. I understand that I am responsible to notify The Company promptly if my financial status changes or if I am able to obtain funding from another source.

Signature of Patient/Responsible Party: _____ Date: _____

For Internal Use Only:

Does patient require full or partial waiver? ☐ Full ☐ Partial Approved Monthly Payment: $_____

Does patient require full or partial waiver of his/her annual deductible? ☐ Full ☐ Partial Approved Deductible Payment: $_____

Comments:

The request for financial assistance has been ☐ Approved ☐ Denied

Manager Signature: _____ Date _____

Revenue Manager Signature (If applicable): _____ Date _____