Curative Care Center
Health Care Clinic

# Financial Assistance Application Form ——Confidential

*Please fill out all information completely. If it does not apply, write "NA". Attach additional pages if needed.*

## SCREENING INFORMATION

Have you applied for Medicaid? ☐Yes ☐NO

Do you receive state public services such as TANF, Basic Food, or WIC? ☐Yes ☐NO

Are you currently homeless or unstably housed ? ☐Yes ☐NO

## PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

## CLIENT INFORMATION

| **Client First Name** | **Client Middle Name** | **Client Last Name** |
|---|---|---|
| ☐**MALE** ☐**FEMALE**<br>☐**OTHER** (may specify_____) | **Date of Birth** | **Social Security Number** *(optional*)* |

**Mailing Address**

_____

_____

City State Zip Code

**Main Contact Number(s)**

CELL: _____

HOME: _____

Email Address:

_____

| **If someone else provides more than half of your financial support, please check the following box.** ☐ | **If yes, please provide the following :**<br>**Name :**_____ | **Relationship to Client :**_____ |
|---|---|---|

## EMPLOYMENT STATUS OF CLIENT

| | | | |
|---|---|---|---|
| ☐Employed (date of hire:_____)<br>Employer:_____ | ☐ Self Employed | ☐ Disabled | ☐ Retired |
| ☐Unemployed (how long:_____) | ☐ Student | ☐ Other_____ | |

## HOUSEHOLD INFORMATION

List household members and dependents below. *ATTACH ADDITIONAL PAGE IF NEEDED*

HOUSEHOLD SIZE (Including self):_____

| Name | Date of Birth | Relationship to Client | If 18 years old or older: Employer(s) name or source of income | Total Monthly Income |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

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## INCOME INFORMATION

**REMEMBER: You must include proof of income with your application**

You must provide details about your income and household expenses. Income verification is required to determine the capacity of Curative Care Center's financial assistance. All family members 18 years old or older must disclose their income.

**Please provide proof for every identified source of income.**

**EXAMPLES OF PROOF OF INCOME INCLUDE:**

- *A "W-2" withholding statement; or*
- *Current pay stubs (3 months); or*
- *Last year's income tax return, including schedules if applicable; or*
- *Written signed statements from employers or others; or*
- *Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or*
- *Approval/denial of eligibility for unemployment compensation*

**CLIENT'S TOTAL MONTHLY INCOME:**_____

**PLEASE LIST ALL ADDITIONAL MONTHLY ASSISTANCE BELOW ( This includes but not limited to: state, local, and governmental.)**

FOOD/ NUTRITION ASSISTANCE: $_____ AGENCY:_____

HOUSING ASSISTANCE: $_____ AGENCY:_____

**If you cannot provide income documentation, have no income, OR someone else provides more than half of your financial support, you may submit a written signed statement describing your financial statement.**

## MONTHLY EXPENSES

**We use this information to get a more complete picture of your financial situation**

Housing: $_____

Medical Expenses: $_____

Insurance Premiums: $_____

Utilities: $_____

Gas/Transportation: $_____

Food: $_____

Other _____: $_____

Other _____: $_____

**TOTAL MONTHLY EXPENSES:**

## ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, seasonal/temporary income, or personal loss.

## PATIENT AGREEMENT

I understand that Curative Care Center may verify information by reviewing and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of any additional financial assistance that does not directly affect treatment compliance.

**Client Signature**: _____ **Date Signed**: _____