REQUEST FOR FINANCIAL ASSISTANCE

I,_____, request financial assistance in paying for the costs of medical treatments provided by Family Health staff for the following household member(s).

	NAME	BIRTH		NAME	BIRTH
1			4		
2			5		
3			6		

I understand that it is Family Health's Policy to treat patients for needed medical services regardless of the patients ability to pay the full costs of that care. Family Health shall determine in its sole discretion what portion of its regular charge will be discounted based on the information provided on this application. **I have already** fully informed Family Health of any and all health insurance benefits available to household member and **understand** that no discount will be applied until a claim response has been received from any and all applicable insurance.

I agree to fully inform Family Health of the source and amount of ALL household income available to me and my family including, but not limited to, employment, unemployment, disability, retirement, and child support.

I also understand that if I qualify for financial assistance from Family Health, any reduction in the portion of the full fee that I must pay is dependent upon my carrying out the following responsibilities:

I agree to carry out the treatment recommendations fully and completely and agree to notify Family Health of any situation which prevents me from fully complying with the treatment plan.

I agree to pay the portion of the full charge which is determined to be my direct responsibility at the time of service or make payment arrangements to assure prompt and full payment. It is my responsibility to inform Family Health of any circumstances which prevents me form meeting this obligation and my responsibility to make new arrangements necessary to meet this financial obligation.

I understand and agree that my failure to fulfill the above responsibilities may result in removal of all financial adjustments made as a result of this application. In this event, I understand that I will be financially responsible for the full charges for all care rendered under this understanding.

Further, **I understand** that any falsification of information provided herein will terminate my right and that of my family to any financial assistance.

The Following household members have income earned from work or other sources: (show gross income before deductions from child support, disability, work, unemployment, social security, etc.)

HOUSEHOLD MEMBER	EMPLOYER/INCOME SOURCE	GROSS INCOME
		$ per
		$ per
		$ per

I have read, understood, and accept the above conditions to this application for financial assistance.
I authorize Family Health to verify income from any source including employers, governmental agencies, and other household members and/or references.

Signed: _____ Date:_____

EXPIRATION DATE

PLEASE NOTE: this information must be updated every year or immediately in the event of an income change!

OFFICE USE ONLY:	Annual Income	Family Size	Discount $	Name