

## Financial Assistance Application

### APPLICANT INFORMATION

**\*ALL FIELDS MUST BE COMPLETED**

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Years Employed: \_\_\_\_\_

Number of Household Members and Dependents (*include yourself*): \_\_\_\_\_

### Household Members & Dependents by Legal Name

Name (Last, First, MI)	DOB	Age	Relation	Occupation

#### Patient's Income Information:

Salary: \$ \_\_\_\_\_

Is this amount:  Hourly  Monthly  Yearly

Does you work:  Full Time  Part Time

Unemployment: \$ \_\_\_\_\_

Social Security or Disability: \$ \_\_\_\_\_

AFDC: \$ \_\_\_\_\_ Child Support: \$ \_\_\_\_\_

Savings Account: \$ \_\_\_\_\_

Checking Account: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

#### Spouse/Household Member's Income Information:

Salary: \$ \_\_\_\_\_

Is this amount:  Hourly  Monthly  Yearly

Does you work:  Full Time  Part Time

Unemployment: \$ \_\_\_\_\_

Social Security or Disability: \$ \_\_\_\_\_

AFDC: \$ \_\_\_\_\_ Child Support: \$ \_\_\_\_\_

Savings Account: \$ \_\_\_\_\_

Checking Account: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

#### Monthly Expenses:

Rent or Mortgage (Primary and Secondary) \$ \_\_\_\_\_

Utilities (Electric, Gas, Water) \$ \_\_\_\_\_

Outstanding Medical Bills (Non-Advanced) \$ \_\_\_\_\_

Childcare/Adult Care \$ \_\_\_\_\_

Please name your primary Advanced Urology Provider(s): \_\_\_\_\_

Have you recently been approved for Financial Assistance with another provider's office or hospital? If so, please list name: \_\_\_\_\_

**Other Coverage Questions:**

Do you have health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you being treated for injuries covered by third party liability, such as Workers Compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you applied for Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that if any information I have given proves to be untrue, Advanced reserves the right to re-evaluate my financial status and take whatever action becomes appropriate:**

Patient Name (PRINT) : \_\_\_\_\_

Patient Signature : \_\_\_\_\_ Date : \_\_\_\_\_

**Documentation to support your application is required in order to process the application. At any time during the application process, Advanced may request additional documentation to assist in the determination of your eligibility for Financial Assistance. Failure to provide this information could result in your application being denied or suspended. Please ensure all required documents outlined in the instructions are submitted with this form.**

*Should your financial situation change, Advanced may request a new application. A determination of eligibility for financial assistance will be effective for a maximum of 12 months and will need to be reassessed thereafter. Any misrepresentation of the above information may result in the retroactive denial or reduction of financial assistance and the patient/guarantor being held liable. In addition, Advanced reserves the right to evaluate a patient's eligibility under the Advanced Financial Assistance Policy yearly and to adjust the patient's account as necessary.*