



Application for Financial Assistance

Please fill out all information completely. If it does not apply, write "NA."

CLIENT AND APPLICANT INFORMATION:

Client's full name (please print): _____

Have you (the client) applied for Medicaid in the last six months? Yes No

Are you (the client) currently homeless? Yes No

Name of person responsible for paying bill (please print): _____

Employment status of person responsible: Employed Unemployed Disabled
 Retired Student Other _____

HOUSEHOLD INFORMATION:

Please list family members in your household, including yourself. "Family" includes people related by birth, marriage or adoption who live together.

Total family members in household (Attach additional page if needed): _____

<u>Name</u>	<u>Relationship to client</u>	<u>Age</u>

Monthly household expenses (only required if client is adolescent):

Mortgage/Rent: _____ Utilities: _____ Cell Phone: _____
 Cable/Internet: _____ Food: _____ Taxes: _____
 Automobile Payment: _____ Auto Insurance: _____ # of Vehicles: _____
 Gas for vehicle: _____ Other Insurance: _____ Other expenses: _____

INCOME VERIFICATION:

Gross (before taxes) monthly household income (*required to determine financial assistance*): _____

Please select the income verification you are providing and attach to this application, you may need to provide more than one type. Please select all that apply:

Social Security Wage Earning Statement SSA-1099 (Social Security/Disability Tax Statement)
 1099-G (Unemployment Statement) Pay check stub (2 weeks) W-2(s) 1040
 Child/Spousal Support Pension/Retirement Workers Compensation

I declare that the above information is true and correct to the best of my knowledge.

Signature of Applicant: _____ Date: _____