Financial Assistance Program Application

Application for Free Care and CCS Sliding Fee Discount for FQHC

Patient Full Name	**Account Number:**
Address	**State** **Zip**

Family/Household Member Information (Spouse, and biological or legally adopted children under 18 years old.)

First and Last Name	Relationship to Patient	Date of Birth	Social Security Number	Are you a citizen? Y Or N	List Medical Insurance and ID for each member. If this application is for a motor vehicle accident or workers' compensation, please also list here.

Household Income

Proof of gross household income for 3 months prior to signature date of application is REQUIRED for all family members to include paystubs, benefit award letters, and self-employment ledgers or returns. Sources of income, include, but not limited to, wages, salaries, tips, taxable amount of pension, annuity or IRA distributions, Social Security benefits, VA benefits, unemployment, TANF, General Assistance, child support, alimony, worker's compensations benefits, rental income. For self-employed, provide a copy of the previous year's income tax return, including the Schedule C.

Household Member/Employer	Last 3 months income	Last 12 months income

If you have no income, explain your living situation (food/shelter/etc.):

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By signing below:

I permit the request for proof of income as noted above. I understand that more information may be requested.

I permit the release of any medical, financial, or employment information that relates directly to my health care or to my financial assistance eligibility. This information may be released to any health care providers from whom I and any household members have received health care services or financial assistance. All information provided will remain confidential under HIPAA federal regulations. Any discounts apply to all balances within the approved period for medically necessary services provided by Covenant Health.

If I am approved for Financial Assistance:

- I understand that I will lose the assistance if I have not fully and correctly presented my income, if I have provided any false information, or if I have not disclosed my insurance coverage. If I lose the assistance, I agree to pay the balance on my account. I also agree to pay any legal fees for the collection process.
- I agree to repay any money if I receive other payment for the medical services covered. Such payments may include insurance payments, governmental program programs, and awards from a lawsuit.

I agree to tell Covenant of any changes that could affect my eligibility, including changes to family size, income, and health insurance coverage. If I might qualify for a public assistance program, I will apply to that program and provide Covenant with the proof of application.

Applicant Signature: **Date:**

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