Gastroenterology Associates

Gastroenterology and Hepatology
olygastro.com

FINANCIAL ASSISTANCE APPLICATION

Date:_____ Account Number:_____

SCREENING INFORMATION
Is the patient currently homeless?
We require denial of an application for Medicaid/DSHS insurance in order to be eligible for consideration of financial assistance. If you've been denied, please submit a copy of the denial letter.
Does the patient currently receive state public services such as TANF, basic food, or WIC?

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in the application, we may check all the information and may ask for additional information.
- All information must be completed in order to process this application.

PATIENT AND APPLICANT INFORMATION			
Patient First Name:	Patient Middle Name:		Patient Last Name:
Birth Date:	Patient SSN:		Employment Status:
Person Responsible for paying the bill:	Relationship to patient:	Birth Date:	SSN:

Mailing Address:	Main Contact Number(s) ( ) ( )

Employment status of person responsible for paying bill:
Length of employment (if applicable) _____ Length of unemployment (if applicable) _____
If you are not employed, how do you pay for basic needs (food, housing, etc.)?

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. Children must be under 18 years old or full-time students.

Family size: attach additional page if necessary

Name	Date of Birth	Relationship to patient	If 18 years or older, employer name or source of income	If 18 years or older, total gross monthly income (before taxes)

All adult family members' income must be disclosed. Examples of income include:
-wages -unemployment -self employment -workers' compensation -disability -SSI
-child/spousal support -work study programs (students) -pension -retire account distributions

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INCOME INFORMATION
REMEMBER: You must include proof of income with your application. If you do not have income, a statement about how you are meeting your basic living expenses (food, shelter) is required.
You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years or older must disclose their income. Please provide proof for every identified source of income. • A "W-2" withholding statement, or • Current pay stubs (at least 1 month), if this fluctuates, 3 months is required • Last years' income tax return, including schedules, if applicable • Statements showing unemployment amounts, social security, retirement, or any other income
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 financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.
PATIENT AGREEMENT
I understand that my information may be verified, and information may be obtained from other sources to assist in determining eligibility for financial assistance or payment plans. The information in this application is true, complete, and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I will be responsible and expected to pay for services provided. _____ _____ Signature of person applying Date