APPLICATION FOR FINANCIAL ASSISTANCE

In order for CRMC Medical Group Primary Care Clinic to process your application all sections must e completed Please return application to: Director of Medical Group Allo days from receipt for processing of your application If financial assistance is a arded it ill apply to all ser ices recei ed at this clinic ut not outside this clinic including reference la oratory testing drugs ray interpretation and other such ser ices You must complete this forme er months or if your financial situation changes For this application to e complete you must su mit:

Proof of income for allincome sources (pre iousyear s ta return last pay stu s s socia ecurity supplemental security income alimony child support unemployment retirement pension interest income from rental properties assistance from outside the household etc)

SECTION ONE: APPLICANT INFORMATION

Applicant Name: _____ Date of Birth: ___/___/___
LAST NAME FIRST NAME MIDDLE NAME

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Email: _____

SECTION TWO: ADDITIONAL HOUSEHOLD MEMBERS INFORMATION

Please provide the below information for all immediate family members who live in your home.
- For these purposes "family" includes the applicant, applicant's spouse, and all of their children under 18 (natural or adoptive).

	Additional Family Member Name(s)	Date of Birth	Relationship to Applicant
1.			
2.			
3.			
4.			
5.			
6.			

SECTION THREE: FINANCIAL INFORMATION

Please provide any income and assets that members of your household receive.

Income Source	Current Monthly Gross Income - Applicant	Current Monthly Gross Income - Spouse/Other
Employment Income		
All Other Income Sources		

SECTION FOUR: INSURANCE INFORMATION

Please provide your health insurance/medical coverage information, if applicable.

Insurance Company Name: _____ Phone Number: _____

Group Number: _____ Member ID Number: _____

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this medical bill(s). I understand that the information provided may be verified, and I authorize CRMC Medical Group Primary Care Clinic to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the medical bill(s). I grant CRMC Medical Group Primary Care Clinic permission to contact me using any method provided on this application.

Signature of Applicant: _____ Date: _____