

AMT East Financial Assistance Program Application

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|--|------------------------------|--------------------------------|----------------------------|
| AMT East Financial Assistance Program Application | | | |
| | | | |
| Patient Name | Social Security # | Birth Date | Age |
| | | | |
| Responsible Party's Name | Social Security # | Birth Date | Relationship to Pat |
| | | | |
| Guarantor Address | | # of Years | Home Telephone # |
| | | | |
| Dependent Name(s) | Age(s) | Dependent Name(s) | |
| | | | |
| | | | |
| Employer Information | | Spouse's Employer Info. | |
| Name: | | Name: | |
| Street: | | Street: | |
| City, State, Zip: | | City, State, Zip: | |
| Job Title: | | Job Title: | |
| # of Years Worked: | | # of Years Worked: | |
| Work Phone #: | | Work Phone #: | |
| Income Information | | | |
| Income Source | Hours Worked per Week | Hourly Wage | |
| Patient | | \$ | |
| Spouse/Responsible Party | | \$ | |
| Working Children | | \$ | |
| Social Security | | | |
| Pension(s) | | | |
| Child Support | | | |
| SSI/SSDI | | | |
| Unemployment | | | |
| Commissions | | | |
| Tips | | | |
| Farm Income | | | |
| Rental Property | | | |
| Interest Income | | | |
| Total Monthly Gross Income | | ➡ | \$ |
| Banking Information | | | |
| Name of Bank | Checking Acct Balance | Savings Acct Balan | |
| | \$ | \$ | |
| Property Information | | | |
| Property Owned | Yes/No | Property Location | |
| Home | | | |
| Rental Property | | | |
| Farm Land | | | |
| Other Property | Yes/No | Make/Model/Year | |
| Vehicle #1 | | | |
| Vehicle #2 | | | |
| Total Approx Value of Property Owned | | ➡ | |
| | | | |
| Monthly Expenses | Monthly Payment | Payment Made To | |

| | | | |
|-----------------|-----------------|------------------|--|
| Rent/Mortgage | \$ | | |
| Car Loans | \$ | | |
| | \$ | | |
| Hospital Bills | \$ | | |
| | \$ | | |
| | \$ | | |
| | \$ | | |
| Doctor bills | \$ | | |
| | \$ | | |
| | \$ | | |
| | \$ | | |
| Other Expenses | Monthly Payment | Other Expenses | |
| Gas/Electric | \$ | Health Insurance | |
| Telephone/Cell | \$ | Groceries | |
| Cable/Satellite | \$ | Medication | |

INCOME CERTIFICATION

I certify that my gross household income for last year was \$_____ and that there are _____

Have you applied for Medicaid and/or any other state/county assistance? ___Yes ___No

| | | | |
|------------------|-------------------------|--|--|
| Application Date | Program(s) Applied For: | | |
| | | | |
| | | | |
| | | | |

I acknowledge indebtedness to AMT East for services received and billed to me. I have applied for Medicare third party benefits for which I am eligible. All Medicare, Medicaid, or insurance benefits due to me have account(s). I am financially unable to pay the balance due and request financial assistance for the outstanding account(s). I am financially unable to pay the balance due and request financial assistance for the outstanding account(s). I certify that the information submitted is true and accurate.

Patient or Responsible Party Signature:_____ Date:_____

IMPORTANT: Income Verification must be submitted with Financial Assistance Program Application. This includes W-2 Stubs, W-2 Form, Social Security Information, Tax Forms, and Bank Statements.

This Section is for Office Use Only

| | | |
|--|--------------|-------|
| Eligible for _____% financial discount | Approved by: | Date: |
|--|--------------|-------|

| | | |
|---|------------|-------|
| Not eligible/exceeds charity guidelines | Denied by: | Date: |
|---|------------|-------|

Additional Comments:

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|----------------------------|--|--|
| | | |
| | | |
| Marital Status | | |
| | | |
| Client | | |
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| Age(s) | | |
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| Gross Annual Income | | |
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| | | |
| Net Income | | |
| | | |
| | | |
| Approx Value \$ | | |
| \$ | | |
| \$ | | |
| \$ | | |
| Approx Value \$ | | |
| \$ | | |
| \$ | | |
| \$ | | |
| | | |
| Total Amount Due | | |

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| \$ | | |
| Monthly Payment | | |
| \$ | | |
| \$ | | |
| \$ | | |
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| _ people in my family. | | |
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| aid and/or any other been applied to this standing balance(s). I | | |
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| ese items include: Pay | | |
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