Date Received by Site:	___________________________
Primary Site:	___________________________
CareLogic MRN:	___________________________
Date Received by FCT:	___________________________

Financial Assistance Application

Today's Date: ________________________________

Patient's Name:________________________________ Home Phone: __________________________

Street Address: ________________________________ Cell Phone: __________________________

City: ____________________________ State: _____ Zip: ______

1. This application must be completed in its entirety to be considered for financial assistance.
2. Please list all family members (including yourself). Family members include the applicant, spouse, children (natural or adoptive) under the age of 18 in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security/Pension benefits, alimony, public assistance, self-employment, etc. Income also includes rent or living expenses that are being provided for you.

Family Member	Age	Relationship to Patient	Income Source	Income for 3 months prior to date of service	Income for 12 months prior to date of service
1.		Self			
2.					
3.					
4.					
5.					
6.					

Send proof of three months of gross income with this application:

Gross income is total income before taxes are taken out, and includes but is not limited to:

- Three consecutive months of pay stubs or all pay stubs within the last three months if not employed for three months.
- Copy of previous year's federal tax return.
- Social security, unemployment, alimony, child support, workers compensation award letter, or retirement income documentation in the form of a written statement, or verification of benefits from the applicable agency.
- Any other income statements.

3. If you reported zero total income, how are you being supported?

   ____

   ____

   Please have the following support statement completed by the person(s) helping to support you and/or your family.

Financial Assistance Application

Support Statement

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being supported financially. List services, if any, that you are receiving for providing this support.

____

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____

____

I certify that all of the above information provided is true and correct to the best of my knowledge. My signature does not obligate me to provide financial support related to the medical service of the applicant.

Signature of person providing financial support to applicant

Address of responsible party

City, State **Zip Code**

4. Have you applied for Medicaid or any other county assistance? ___ No ___ Yes (Date/State ________________)
5. Did you have health insurance on the date of service? ___ No ___ Yes (Provide a copy of your card)

By signing this document, I affirm the answers on this application are true. Should further review of an individual's financial assistance application reveal that information provided was either incorrect of fraudulent, the decision to provide assistance may be reversed and the responsible party will be billed.

Patient Signature: ____ Date: ________________

Applicant or Representative Signature: ___________________________ Relationship: _______________ Date: _________

Mail completed application and documentation to:

Brightview, LLC
P.O. Box 639886
Cincinnati, Ohio 45263-9886