Family Assistance Plan Application

It is the Wilkens Medical Group policy to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. Please complete the following information and return to the Billing Office to determine if you or a member of your family may be eligible for a discount.

The discount will apply to all services received at the clinic, but not those services which are purchased from outside such as reference laboratory testing, drugs, x-ray interpretations by a consulting radiologist, and similar services. In the hope that your economic health improves, discounts apply only to current, not future services. This form must be completed yearly and approved before seeing a provider. Please inquire at the Billing Office if you have questions.

Number of people living in your household: ☐

Name of Head of Household:		Employer:
Street:	City:	State & Zip:

Please list all people living in the household:

Name		Date of Birth	Name		Date of Birth
Self			Dependent:		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		
Dependent			Dependent		
Other			Other		

Annual Household Income

Source	Self	Spouse	Dependent	Other	Total
Gross Wages, Salaries, Tips etc.					
Social Security, Pension, Annuity & Veteran's Benefits					
Alimony, Child support & Military Allotments					
Income from Business Self Employment					
Rent, Interest Dividend & Other Income					

Please turn over, view the Verification Check List, attach requested items, sign & date the application. Your application will not be processed if your application is not complete and documentation is not attached.

Verification Check List (attach copies)

Our office will make copies of your original documents if needed.

Required Documentation	For office use only

Identification/Address: Driver's License, Social Security Card	Yes		No	
Income: Last year's tax return, last three (3) check stubs for all employed applicants, proof of reduced or free lunch approval or letter from BISHOP/CLERGY who knows family's financial situation.	Yes		No	
Current Insurance, Medicare or Medicaid information	Yes		No	

I certify that the information is correct and that verification is required for approval.

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Print Name

______________________________ ______________________

Signature Date

FOR OFFICE USE ONLY

Received Date: ______________

Discount Amount: ______________

Approval Date: ______________

Expiration Date: ______________

Approved By: ______________________