Patient Financial Assistance Application

Pennies with Purpose

Patient Name:		Date:
Patient Address:		
City:	State:	Zip Code:
Telephone:	Date of Birth (MM/DD/YY):	

Requested Service or Item:	Approximate value: $ _____

1. Do you have medical insurance coverage? ☐ Yes ☐ No

   If "Yes," please list responsible party information: (Please include a copy of your insurance card.)

   Insurance Carrier Name: _____
   Policy Name: _____ *ID#:*_____

2. Total Gross Annual Household Income*: $_____ Number of Persons in household: _____
   (include yourself and those you are financially responsible for)

   **Total household income includes the following for all members of your household: Gross Salary, Unemployment Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.), Other Income*

3. (Optional) Please advise of any extenuating circumstances that you would like us to consider. If you need additional space, please write on the back of this form or use a separate sheet of paper.

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE PWP TO VERIFY THE ABOVE INFORMATION FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED, INCLUDING THE RIGHT TO SEEK SUPPORTING DOCUMENTATION FOR THE ABOVE REQUEST. I UNDERSTAND THAT IF I DO NOT QUALIFY, I WILL BE NOTIFIED.

Patient or Responsible Party Name (Print): _____

Patient or Responsible Party Signature: _____

Name of Facility _____

Social Worker /Health Care Professional Name (Print) _____ *Signature* _____

FOR INTERNAL USE ONLY:

☐ Approved as requested above

☐ Approved and modified as below:

_____

☐ Denied

Reason for denial: _____

Reviewer/Signature: _____ *Date Reviewed*: _____