Patient Financial Assistance Application

Pennies with Purpose

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

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*** _____

Please return this form by Email, fax or mail.

Email – info@pennieswithpurpose.org
or
Fax to: 404-443-0916
or
Mail to: Pennies with Purpose
167 Iveydale Road
Mableton, GA 30126

Questions please call – 770-693-5929

FOR INTERNAL USE ONLY:

☐ Approved as requested above

☐ Approved and modified as below:

_____

☐ Denied

Reason for denial: _____

Reviewer/Signature: _____ ***Date Reviewed***: _____