ECONOMIC ASSISTANCE REQUEST

Patient's Name**:** _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Please complete the information below completely – incomplete form will delay review and processing

1. Are you married? ☐Yes or ☐No
2. How many dependents do you have? 1 2 3 4 5 6 7 Other_____
3. What is your current household size? (Include spouse, children, and legal dependents living in your home)_____
4. Are you receiving any type of assistance from local, county, state, or federal government agencies? ☐Yes or ☐No
   a. If so, describe the assistance - _____
5. Is a guardian or anyone else legally responsible for your medical bills? ☐Yes or ☐No. Provide the person's name, address, and phone number: _____
   _____
6. Do you own your house? ☐Yes or ☐No. If yes, is it paid for? ☐Yes or ☐No. If no, how much is each monthly payment? _____.
7. Do you or anyone in your household have any unpaid medical and/or other bills? ☐Yes or ☐No. If yes, please explain and provide dollar amount(s) owed:_____
   _____
8. How much do you have in savings to which you have immediate access (not including qualified retirement)? _____
9. What is your monthly net income from the following:

Your employment	_____	Retirement	_____	Spouse	_____
Social Security	_____	Investments	_____	Disability	_____
Child Support	_____	Other	_____	**Total**	_____

10. What are your monthly expenses

Rent/house payment	_____	Insurance (all)	_____	Car payment	_____
Rx/Medical	_____	Food	_____	Utilities	_____
General	_____	Other	_____	**Total**	_____

I certify that the above information is true / correct and I request that the co-insurance (Medicare or other) be waived.

Patient's Signature**:** _____ Date_____

Any supportive information regarding income or expenses that is provided with this form is helpful in determining whether economic assistance can be provided or not. This can include, but not be limited to, a tax return, pay stubs, social security checks, retirement income, disability paperwork, unemployment papers, car payment verification, or rent/house payment information. Doc Supply Rehab may request such information to verify the application. It is the patient's responsibility to inform Doc Supply Rehab of any positive change in the patient's financial situation that would nullify his or her qualification for the waiver. Waiver is good for 12 months if approved.

This Economic Assistance Request is for review and does not guarantee receipt of a financial hardship waiver.

For office use only: Reviewed by: _____ Date: _____
Notes: