



FINANCIAL ASSISTANCE PROGRAM CHECKLIST

PATIENT NAME: _____ **DATE:** _____

If you have difficulty providing these documents, please discuss alternatives with your Financial Navigator.

PROOF OF INCOME:

- Complete most recent Federal Tax Returns including all schedules
 - If employed: Paycheck stubs for the last 2 pay periods or 2 bank statements
 - If self-employment: Please provide at least one of the following:
 - 1. IRS Wage and Tax Statement for Self Employed (Form 1099).
 - 2. Bank statements for 2 months
 - Unemployment, Disability Income, etc. (monthly). Copy of check if disabled/unemployed longer than 6 months
 - Child Support, Alimony (monthly): copy of your divorce decree, legal separation notice or custody agreement
 - Other (as requested by your Financial Navigator): _____
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MEDICAL BILLS

- Copies of all outstanding medical bills from all sources
- Documentation of any payment plans for medical bills outstanding

MEDICAID APPLICATION

- Completed Medicaid Application
- Denial letter from Medicaid

OTHERS: _____

Your Financial Navigator is Tala Kent. Her telephone number is 435-719-3542.