



**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): \_\_\_\_\_

**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 Randall. Her telephone number is 435-719-3542.**