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 Connie Beason. Her telephone number is 435-719-3536