Financial Assistance Program Application

*Please Print Date: _____

PATIENT INFORMATION

MR# _____ Social Security Number: _____

Name: _____ D/O/B: _____/_____/_____
(Last) (First) (MI) (MM/DD/YY)

Present Address: _____
(Street/Apt Number) (City) (State) (Zip)

Previous Address: _____
(Street/Apt Number) (City) (State) (Zip)

Telephone Number: (___) _____ (____) _____ (____) _____
(Home) (Work) (Cell)

RESPONSIBLE PARTY INFORMATION

Name: _____ D/O/B: _____/_____/_____
(Last) (First) (MI) (MM/DD/YY)

Present Address: _____
(Street/Apt Number) (City) (State) (Zip)

Previous Address: _____
(Street/Apt Number) (City) (State) (Zip)

Telephone Number: (___) _____ (____) _____ (____) _____
(Home) (Work) (Cell)

Relationship to Patient: _____ Social Security Number: _____

List all persons residing in household:

	Name	Age	Disabled?	Annual Income
Head of House	_____	_____	Y/N	_____
Spouse	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Other Dependents	_____	_____	Y/N	_____

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(Last) (First) (MI)

INCOME

DESCRIPTION	MONTHLY INCOME
List monthly income from any of these sources.	
A. GROSS SALARY for husband	$ _____
NET SALARY for husband	$ _____
EMPLOYER NAME _____	
B. GROSS SALARY for wife	$ _____
NET SALARY for wife	$ _____
EMPLOYER NAME _____	
C. DIVIDEND AND INTEREST	$ _____
D. RENTAL INCOME	$ _____
E. PENSION INCOME	$ _____
F. CHILD SUPPORT (INCOME)	$ _____
G. ALIMONY (INCOME)	$ _____
H. ADDITIONAL INCOME	$ _____
I. SOCIAL SECURITY BENEFITS	$ _____
J. V.A. BENEFIT	$ _____
K. WELFARE	$ _____
L. OTHERS-LIST	$ _____
	$ _____
	$ _____
	_____
Total Income Per Month	$ _____

EXPENSES

DESCRIPTION	MONTHLY EXPENSE
A. RENT/HOUSE PAYMENT	$ _____
B. FOOD	$ _____
C. UTILITIES	$ _____
	(Elect/Water/Phone/Gas)
D. REPAIRS	$ _____
	(Car or Home)
E. INSTALLMENT LOANS-List:	$ _____
F. _____	$ _____
G. CAR PAYMENT	$ _____
H. OTHER CHARGE ACCOUNTS	$ _____
I. VISA/MASTER CARD	$ _____
J. CELL PHONE/PAGER	$ _____
K. CABLE TV	$ _____
L. CHILD SUPPORT	$ _____
M. ALIMONY	$ _____
N. CHILD CARE	$ _____
O. MEDICAL TRANSPORTATION	$ _____
P. EDUCATION (Students Only)	$ _____
Q. MONTHLY MEDICATION(S)	$ _____
Total Expenses Per Month	$ _____

ASSETS

DESCRIPTION	VALUE AMOUNT
A. CHECKING ACCOUNT	$ _____
BANK NAME _____	
B. SAVINGS ACCOUNT	$ _____
BANK NAME _____	
C. IRA	$ _____
D. INSURANCE POLICY	$ _____
E. HOME	$ _____
Total Assets	$ _____

DESCRIPTION	VALUE AMOUNT
F. CAR	$ _____
G. OTHER ASSETS-List	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

I understand that the information I submit is subject to verification by The University of Alabama Health System and subject to review by state and/or federal enforcement agencies and others as required.

I am consenting financial assistance administrative services for The University of Alabama Health System. I certify under the statutes of perjury that the information on these pages is true and correct, and that I do not have the financial means to pay for medical care rendered to the above patient.

If my financial situation changes in the upcoming calendar year, I will report these changes to the University of Alabama Health System immediately.

*My signature on this application verifies that if I am entitled to any other medical benefits, including, but not limited to, a supplemental insurance policy, that I will provide the University of Alabama Health System with this information. Should I choose not to give any information regarding my supplemental insurance carrier, my application for assistance may be denied and I may be responsible for the total amount of the bills accrued at the University of Alabama Health System.

**Financial assistance does not include medication.

Signature of Responsible Party: _____ Date signed: _____

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Please answer the following questions:

Are you currently on dialysis for kidney disease? Yes ___ No ____

Are you a kidney transplant patient? Yes ___ No ____

Insurance Information:

Do you have health insurance? If so, list below:

	Insurance Company	Policy #	Group #
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Is health insurance available to you through your employer? Yes _____ No_____

Have you declined health insurance coverage offered to you by your employer or through responsible person's employer? Yes _____ No_____

Have you received or do you expect to receive a Third Party Liability settlement related to an accident or injury resulting in your admission to UAB? Yes _____ No_____

If your admission is the result of an accident or injury, are you represented by an attorney? Yes _____ No_____ If yes, please complete the following information:

Attorney name: _____
Attorney address: _____
_____

Attorney telephone: _____

Are you eligible to apply for the Affordable Care Act health insurance coverage? Yes _____ No_____

If yes, what was the outcome? Provide insurance information or other outcome.
_____

If no, why are you not eligible to apply? _____

My signature below attests that the above information is valid and true.

Signature: _____ Date: _____

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 Name: _____
(Last) (First) (MI)

Financial Assistance Program and discounted care does not cover the following services:

- Organ transplants
- Reconstructive surgery
- Cosmetic surgery
- Breast implants
- Breast reduction
- Teeth extractions, excluding radiation or transplant patients
- Dentures
- Genetic testing that is required for determining treatment will be covered but all other genetic testing will be charged to the patient
- Treatment for infertility, including but not limited to artificial insemination
- Addiction Recovery Service
- Medications
- Durable medical equipment
- Services not normally covered by health insurance
- Primary Care services

This is an example of services not covered under the Financial Assistance Program or Discount Care Program. This list may not include all exclusions to the program.
Should you have questions regarding your particular plan of care, please feel free to call our office.

We reserve the right to change or update covered or non-covered services without notice.

My signature below verifies that I have read and understand the list and statements above.

Signature: _____ Date: _____

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Patient Financial Assistance Program Application
Physician Disability Confirmation

Only complete this form if:
You are pending or have been denied disability benefits but are reporting you are unable to work due to an illness or injury, or if you are temporarily unable to work due to an illness or injury.

Please have your physician answer the following questions in order for us to properly evaluate your Financial Assistance Program application based on your medical condition. We will need specific information about each of the illnesses, injuries or medical conditions that keep you from working. Once completed you, the applicant, will need to return this form along with your application. If you or your physician have any questions regarding this form, please call (800) 249-2645.

Name: _____ D/O/B: _____/_____/_____
(Last) (First) (MI) (MM/DD/YY)

MR#: _____ Social Security Number: _____

Physician Information:

_____ _____
(Name of Physician completing form-**Printed**) Physician Signature & Today's Date

(_____) _____ (_____) _____
Telephone Number Fax Number

1. **What is the major illness, injury, or condition that keeps the patient from working?**

2. **What is the estimated time frame that you expect the patient to be unable to work? (i.e., 1 month, 3 months, 6 months, etc.)**

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