



## Financial Assistance Form

Account# \_\_\_\_\_

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

If Unemployed, How long?: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

If Unemployed, How long?: \_\_\_\_\_

Number of family members living in household:

Name: _____	Age: _____
Name: _____	Age: _____
Name: _____	Age: _____
Name: _____	Age: _____

Family Member's (Living in household) Employer(s): \_\_\_\_\_  
(Include Name, Employer, & Employer phone) \_\_\_\_\_

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### FAMILY INCOME & SOURCE

PATIENT

SPOUSE

FAMILY  
MEMBER

Gross Monthly Salary: \_\_\_\_\_

Public Assistance Benefits: \_\_\_\_\_

Unemployment Benefits: \_\_\_\_\_

Social Security Benefits: \_\_\_\_\_

Workman's Comp: \_\_\_\_\_

Child Support: \_\_\_\_\_

Other (Alimony, Etc.): \_\_\_\_\_

*TOTAL FAMILY INCOME* \$ \_\_\_\_\_

**ASSETS**

Real Estate: \$ \_\_\_\_\_  
Investments: \$ \_\_\_\_\_  
Checking Account: \$ \_\_\_\_\_  
Savings Account: \$ \_\_\_\_\_

Have you ever applied for other hardship programs?    YES    NO  
If yes, please list: Program: \_\_\_\_\_ Date Applied: \_\_\_\_\_  
Application Outcome: \_\_\_\_\_

Have you ever applied for public assistance (*Medicaid, state or local programs*)?    YES    NO  
If yes, date applied: \_\_\_\_\_ Application Outcome: \_\_\_\_\_

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**EXPENSES**

	<i>BALANCE</i>	<i>MONTHLY PAYMENT</i>
Rent/Mortgage	\$ _____	\$ _____
Second Mortgage	\$ _____	\$ _____
Gas & Electric	\$ _____	\$ _____
Water/Sewer	\$ _____	\$ _____
Cable	\$ _____	\$ _____
Phone/Cell Phone	\$ _____	\$ _____
Groceries		\$ _____
Car Payments	\$ _____	\$ _____
Transportation Expense	\$ _____	\$ _____
Taxes and Insurance	\$ _____	\$ _____
Car Insurance	\$ _____	\$ _____
Medication Expense	\$ _____	\$ _____
Hospital Bills	\$ _____	\$ _____
Medical Bills	\$ _____	\$ _____
Medical Bills	\$ _____	\$ _____
Medical Bills	\$ _____	\$ _____
Credit Card (Send Documentation)	\$ _____	\$ _____
Credit Card (Send Documentation)	\$ _____	\$ _____
Credit Card (Send Documentation)	\$ _____	\$ _____
Other _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____

*All information is subject to verification. Any intentional falsification of information provided to this office will result in nullification of any payment plan or hardship discount offered. Financial assistance is based on a case-by-case analysis and based on each single event to determine necessity. Financial assistance is not ongoing and will be re-evaluated by this office as deemed appropriate. Any financial assistance discounts or payment plans must be pre-approved by this office.*





Please provide the following information so we may complete your application:

- \_\_\_\_\_ Attached Financial Assistance Form (**completely filled out and signed**)
- \_\_\_\_\_ Most recent IRS tax forms
- \_\_\_\_\_ Check stubs for the past 30 days for all persons employed in the household
- \_\_\_\_\_ Unemployment check stubs for the past 30 days (if applicable)
- \_\_\_\_\_ Proof of all other income received in the past 30 days
- \_\_\_\_\_ Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
- \_\_\_\_\_ Forms approving or denying eligibility for Medicaid and/or state-funded assistance

***PLEASE RETURN ALL ITEMS ON THIS CHECKLIST TO:***

**Cardiovascular Medicine, P.C.  
1236 E. Rusholme, Ste. 300  
Davenport, IA 52803**