

I. Family Income

List the amount of your monthly income from all sources. Please submit proof of income (W -2, tax returns, pay stubs). You may be required to supply proof of assets and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement	_____
Social Security benefits	_____
Public Assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental Property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, Bonds, CD, or Money Market	_____
Others accounts	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____	Approximate value _____
Automobile	Make _____	Approximate value _____
Additional vehicle	Make _____	Approximate value _____
Additional vehicle	Make _____	Approximate value _____
Total		_____

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit Card (s)	_____
Car Insurance	_____
Health Insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? ___ Yes ___ No

For what service? _____

If you have arranged a payment plan, What is the monthly payment? _____

If you request that the practice extend additional financial assistance, the practice may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the practice of any change to the information provided within ten days of the change.

Applicant Signature

Date