Financial Assistance Application

Patient name: ____

Name of individual providing information: ______________________________

Please answer the following questions completely and to the best of your ability:

Family/Household Size: ____________ Number of dependents: ______________

Patient's Monthly Income: ___________

Patient's employment status: _______________

Additional monthly household income: _____________

Relationship of additional income provider: _____________

Total household monthly income: ____________

Household's monthly expenditures (approximate total): ___________________________

Itemize here:

Mortgage/Rent: _______________ Utilities: _____________________

Medical Expenses (Insurance premiums, prescriptions, co-pays, etc.): ____________

Food: _____________________ Phone/Internet: ___________________

Other (specify) ____

I hereby acknowledge that the information given herein is true and correct. I authorize Lingraphica to verify any information contained in this document for the sole purpose of assessing financial need.

_______________________________ __________

Signature Date

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This document was received on ______________ (date)

By ____ (Name/Title)

Approved, Level: _____ Rejected/Reason: ______________

Approved by: ______________________________________ (Signature)