Patient Assistance Fund Application

I understand that the infromation submitted concerning my annual income, family size and assets, is subject to verification by Heartland Christian Counseling. I also understand that if the information submitted is determined to be false, this will result in a denial of this application and the account balance due will remain my responsibility.

Section One: Patient Information (Please Print)

Which provider do you see?	Date(s) of Service	Social Security Number
Patient Name (Last, First, Middle)		Date of Birth

Address	City	State	Zip Code

Home phone	Cell phone	Other phone	County

Marital Status Single Married Divorced Other_____	Are you a legal citizen of the United States? Yes No	Did you have health insurance or any other coverage at the time of your service? Yes No
Do you file a Federal Tax Return? Yes No If No, Why?_____	Who is the Primary Filer? Self Spouse Other_____	Does anyone in the home receive public assistance? Cash Food Other_____

Section Two: Guarantor/Responsible Party Information

Guarantor/Responsible Party: Name (Last, First, Middle Initial)	Date of Birth	Social Security Number

Address	City	State	Zipcode

Cell phone	Other phone	County	Relationship to Patient

Section 3: Household Infromation (List all people who live in your household)			
Name of Household Member	**Date of Birth**	**Relationship to Patient**	**Is this person listed on your Federal Tax Return?**
1.			
2.			
3.			
4.			
5.			
6.			

Section 4: Expenses (List monthly expenses for all household members)			
House Payment	Car Payment	Heat	Cell Phone
Property Taxes (Year)	Car Insurance	Electric	Groceries
Rent/Lot Rent	Fuel (vehicle)	Phone	Tuition
House/Rental Insurance	Childcare/Child Support	Water/Sewer/Trash Removal	Other:
Health Insurance/Expenses	Life Insurance	Cable/Dish/Internet	Other:

Section 5: Income (List income for all household members)		
Monthly Income Source	**What household member receives this income?**	**Current Monthly Gross Income Amount**
Wages		
Self Employment		
Child Support/Alimony		
Social Security		
Investments		
Pension/Dividends		
Tips/Commissions		
Interest Income		
Rental Income		
Trial Income		
Unemployment		
Worker's Compensation		
Other		

Section 6: Household Assets (List assets for all household members)		
Asset Source	**What household member owns this asset?**	**Current Asset Value**
Checking Accounts		
Savings Accounts		
CDs/Money Markets		
401k/403B/IRA/Retirement		
Property (Home) Value		
Property #2 Value		
Vehicle Values		
Motorcycle/ATV/Boat/Trailer		
Life Insurance (surrender value)		
Stocks/Bonds/Annuity		
HSA/FSA		
Other:		

Section 7: Coverage/Requested Amount (PAF request only)
Patient Reason for Request:
Patient Requested Amount: $

By signing below, I certify that everything I have stated on this application and on any attachments is true.

Responsible Party
Signature:_____

Date:_____

Please call with questions:____(office phone)_____

To be completed by Heartland Christian Counseling Staff for PAF request:

Clinical Staff Signature:_____

Date:_____

Director Signature:_____

Date:_____

To Be Completed by Staff	Patient Responsibility: $	Deductible: $	Meets Requirements:
	Approved: Yes No	Reason if applicable:	Approved $ amount: