Financial Assistance Application Form

To be considered for financial assistance you **must provide** the following:

1. The completed and signed Financial Questionnaire
2. Copies of your **two most recent pay stubs** for each working adult in household to validate income. (If you are self employed, provide copies of **three months** Profit and Loss Statements).
3. Supporting documentation of all forms of income, for example: public assistance award or denial letters, alimony court orders, unemployment benefits, L&I benefits, financial award letter from school/college

If you are claiming no income or there has been a recent change in your financial situation you **must** include a letter of explanation. If someone else is paying for your food and shelter please include a letter of explanation from them.
Applications **must** be returned within **14** days or requests may be denied. Please note that if financial assistance is granted it will only cover your bills from our facility. It will not apply to the bills for other medical groups, hospitals, or physicians groups unless they specifically agree to accept it. **PLEASE CONTACT THE OTHER MEDICAL GROUPS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.**

When applying for financial assistance you are giving consent for us to make necessary inquiries to confirm financial obligations or references.

I understand if I am granted financial assistance for counseling, I will be required to do two (2) hours of community service for every hour I am with a counselor and bring verification from the agency where the community service is performed.

Signature Date

Safe Harbor Counseling Center, Inc.

Charity Care Application
Financial Questionnaire

Personal Information

Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Patient Name: _____ _____

Counselor: _____ _____

Normal Fee: _____ **Adjusted Fee:** _____

Family Size				
Total Family Size: _____	**Name**	**Relationship**	**DOB**	**Citizen Yes or No**
Patient				
Guarantor (if different from patient)				
Spouse				
Child				
Child				
Child				
Child				
Other Family Member				
Other Household Member				
United States Sponsor				

Income (Monthly)				
	Person 1	**Person 2**	**Person 3/Sponsor**	**Grand Total**
Name:				
Gross wages/salary:	$	$	$	$
Employer:				
Phone#:				
Start Date:				
Termination Date:				
Unemployment	$	$	$	$
Public Assistance	$	$	$	$

(Cash)				
Social Security	$	$	$	$
Retirement Benefits	$	$	$	$
VA Benefits	$	$	$	$
Income (Monthly) continued				
	Person 1	**Person 2**	**Person 3/ Sponsor**	**Grand Total**
Workers Compensation	$	$	$	$
Income Producing Property (Rent)	$	$	$	$
Other (Child Support)	$	$	$	$
Other	$	$	$	$
Other	$	$	$	$
Combined Total Monthly Income:	$	$	$	$

Checking/Savings Accounts, Investments, and Insurance			**Balance**
Does your household have a checking account?	☐ Yes	☐ No	$
Does your household have a savings account?	☐ Yes	☐ No	$
Does your household have any Investments, IRA, CD's, etc.?	☐ Yes	☐ No	$
Are you drawing monthly income from Investments?	☐ Yes	☐ No	**Amount per month:** $
Have you applied for Medicaid in the past 90 days? **If yes, what was the determination? (Provide copy of award letter)**	☐ Yes ☐ Approved ☐ Denied	☐ No	**Date:** _____
Do you have Medical Insurance?	☐ Yes	☐ No	

List any other properties you own other than your primary residence.	**Type of Property (house, condo, etc)**	**Tax Assessed Value**	**Outstanding Mortgage**
		$	$
		$	$

I understand that the information provided by me is subject to verification by the Safe Harbor Counseling Center, Inc. . I understand that any false information provided by me will result in a denial of any financial assistance. Financial assistance is available only after all other forms of reimbursement (church, community agency, or family assistance) have been exhausted.

Signature: _____ Date: _____