

Attachment 1: Financial Assistance Application

Patient's Name _____		DOB _____	
Guarantor Name (if not patient) _____		Date of Application _____	
Address _____		City, State, Zip _____	
Guarantor Employer _____			
Number you claim on income taxes			
☐ Single ☐ Married: If married, how many people in household you pay at least half of their living expenses: _____			
(This will include guarantor, spouse and dependent children)			

CURRENT INCOME: Per Month/Year (Gross)	
Patient Employment Income: \$ _____	**Proof of income must be attached
Spouse or Guarantor Emp Income: \$ _____	**Proof of income must be attached
Other Income: (List Source) Examples, Social Security, Disability, Worker's Comp etc.	
1. _____ \$ _____	**Proof of income must be attached
2. _____ \$ _____	
**Proof of income can be paystubs, bank statement, letter from employer, disability determination letter.	
Total Monthly Income \$ _____	**If zero and there is no spouse income, must provide room & board letter from person providing basic living expenses to patient.

PRIOR to INJURY INCOME (No proof required)	
Patient \$ _____	
Spouse or Guarantor \$ _____	

RESOURCES:	
Do you own your home? ☐ No ☐ Yes	(If yes) Estimated Value of Home: \$ _____
Outstanding Loan Amt: \$ _____	
Checking Account Balance: \$ _____	Savings Account Balance \$ _____
Investments/Dividends/Interest, etc. \$ _____	
CURRENT DEBT: Total Amount of Debt other than home mortgage: \$ _____	

FOR SHEPHERD EMPLOYEE TO COMPLETE:	
Shepherd Center Employee's Name: _____	Date: _____
Level of Care: SCI _____ ABI _____	Services requested _____ Reason _____
	Inpt.: _____
	Day Pt: _____
	Outpt: _____
	Other: _____
Has patient applied for GA Medicaid? ☐ Yes ☐ No	Is patient covered by COBRA? ☐ Yes ☐ No
Is patient eligible for OOS Medicaid? ☐ Yes ☐ No	If yes, what state? _____

Patient Agreement:

I understand that the information I have provided will be utilized to assess my ability to pay for services rendered at Shepherd Center and/or to determine my eligibility for financial consideration/assistance. I affirm the above information is true & correct. If requested, I will provide additional information and documentation to further assist in the evaluation of my request for assistance. I agree to cooperate with Shepherd Center with regard to identification and assistance with collection of any other payment sources. I agree that misrepresentation of information on this form will result in forfeiture of financial assistance. (Completion of this agreement does not guarantee approval for financial assistance.)

Signature & Date: _____ Witness & Date: _____