2925 Debarr Road, Suite 240 ● Anchorage, AK 99508 ● Ph: (907) 339-4650 ● Fx: (907) 339-4694
www.neuroversion.com

Financial Assistance Application

Patient Name:_____

Patient Social Security Number:_____ DOB:_____

Name of Responsible Party:_____

Telephone Number:_____

Address:_____

City:_____ State:_____ Zip:_____

Relationship to Patient:
□ Spouse □ Parent/Guardian □ Other

Employer:_____ Responsible Party's employer:_____

Address:_____ Address:_____

City:_____ State:_____ Zip:_____ City:_____ State:_____ Zip:_____

If unemployed, how long?_____ If unemployed, how long?_____

Number of family members living in household:_____

Other family member employer(s), include name, employer, and employer address:
Applies to family members living in the household.

Name of Family Member	Employer	Employer Address

Please continue on the back of this page for additional room.

Family Income and Source

Source	Patient	Spouse	Responsible Party	Other Family Members
Gross Monthly Salary without taxes or deductions				
Public Assistance Benefits				
Unemployment Benefits				
Social Security Benefits				
Workman's Compensation				
Child Support				
Other (Alimony, etc.)				
Total Income				

Other Assistance: _____

Have you applied for Medicaid: [ ] Yes [ ] No

If "yes", provide current status or attach denial letter:_____

Have you tried to obtain financial assistance from other organizations? [ ] Yes [ ] No

List the organizations and current status:

_____

_____

List all outstanding medical bills:

1. _____
2. _____
3. _____
4. _____
5. _____

Please provide any additional information/comments: (Attach additional sheet if more space is required, or use back of this form): _____

_____

Financial Documentation: (attach copies)

Previous year 1040 IRS: $ _____ Year _____

W-2's: _____ Year_____

If patient claims income is less than previous calendar year tax form; attach most recent four pay stubs.

$_____ Date_____

$_____ Date_____

$_____ Date_____

$_____ Date_____

Other (unemployment, Social Security, disability and worker's compensation): (attach copies)

$_____

$_____

$_____

	Monthly Payment
Mortgage/rent	
Gas & Electric	
Telephone	
Car insurance	
Insurance premiums	
Food	
Credit Card(s) **	
Other (Alimony, etc.)*	
Total Monthly Expenses	

**Credit Card Balances

Credit Card: _____
Balance:_____Monthly Payment:_____

Credit Card: _____
Balance:_____Monthly Payment:_____

Credit Card: _____
Balance:_____Monthly Payment:_____

**Other expenses: Please explain:_____
_____

**I declare that I have examined this application and to the best of my knowledge all information in it or otherwise provided to Neuroversion is true, correct, and complete. I understand that misrepresentation of this information may cancel any financial assistance I may be provided and that I will then be liable for all medical charges.*

**By signing and submitting this request, I give Neuroversion permission to determine my need for financial assistance, including review of my credit file. I also give permission to Neuroversion to release or disclose this information to other medical office's that I've stated I owe money to for the purpose of evaluating my financial status in response for assistance with my medical charges.*

**I understand that it is my responsibility to advise Neuroversion of any changes in status in regards to my income or assets while this application is in process.*

Signature of Patient: _____Date:_____

Signature of Responsible Party: _____Date:_____

Return this form and supporting documentation within 30 days to Neuroversion or mail to Nueroversion, Inc. 2925 DeBarr Rd. Suite 240, Anchorage, AK 99508. If you have questions, you may call 907-290-1683.

FOR OFFICE USE ONLY

Application received on:_____

Total wages for calendar year: $_____

Total household: $_____

Eligible discount $_____

Date completed:_____By:_____

Notes:_____

_____

_____

□ Approved

□ Denied

Reason for denial:

□ Does not meet income requirements

□ Did not submit required information

Neuroversion Designee Signature: _____Date:_____