HEALING HANDS
MEDICAL CLINIC

Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as “mission pay”).

Healing Hands Medical Clinic is committed to ensuring our patients get the care they need regardless of ability to pay for that care. Providing health care to those who cannot afford to pay is part of our mission. You may qualify for free or discounted care based on family size and income, **even if you have health insurance**.

What does financial assistance cover? Appropriate and medically necessary clinic-based medical services provided by Healing Hands Medical Clinic. Eligibility is based upon information provided by you in the form of a Financial Assistance Application and supporting income documentation. Income criteria, based on Federal Poverty Level, will be used to determine eligibility for free or discounted care. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application, please contact (480) 442-5863. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

o Provide us information about your family.
- Complete the Family Information section below, including Family Size. Family is defined as “people related by birth, marriage, or adoption who live together.”

o Provide us information about your household gross monthly income (income before taxes and deductions).

o Provide supporting documentation for all household income.
- Examples of acceptable income verification documents listed below.

o Sign and date the form, acknowledging that the information provided is true and correct to the best of your knowledge.

Note: You do not have to provide a Social Security number to apply for financial assistance. If you do not have a Social Security number, please write “not applicable” or “N/A”.

Mail or Email your application with all supporting income documentation to Healing Hands Medical Clinic; ATTN: Patient Financial Assistance, 530 E. Hunt Hwy, Suite 103-485, San Tan Valley, AZ, 85143 or Email billing@healinghandsmc.org.

To receive in-person assistance, Please call 480-442-5863 to schedule an appointment.
We will notify you of the final determination of eligibility within 14 calendar days of receiving a completed financial assistance application, which must include the required supporting documentation.

We want to help! Please submit your application promptly and ensure all supporting income documentation is included. You may receive bills until that time.

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Financial Assistance Application Form – confidential (page 1)

*Please complete this 2 page form in its entirety. If not applicable, write "N/A." *Attach additional pages if needed.*

SCREENING INFORMATION	
Do you need an interpreter? ☐ **Yes** ☐ **No** If Yes, list preferred language: _____	Do you receive state public services, such as FNS/SNAP/Basic Food?
Is your medical care need related to a car accident or work injury? ☐ **Yes** ☐ **No**	Are you currently homeless? ☐ **Yes** ☐ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- We may ask for additional supporting documentation, family information and/or proof of income.
- Within 14 calendar days of receipt of a completed application, we will notify you of your eligibility for assistance.

PATIENT AND APPLICANT INFORMATION		
Patient First Name	Patient Middle Initial	Patient Last Name
☐ Male ☐ Female ☐ Other or N/A	Date of Birth	Patient Social Security Number (optional)
Guarantor (Person Responsible for Paying Bill)	Relationship to Patient	Guarantor Social Security Number (optional)

Mailing Address: _____ _____	Contact Phone: Home: _____ Cell: _____
City: State: Zip:	Email:

Guarantor Employment Status

☐ Employed (date of hire: _____) ☐ Unemployed (date of unemployment: _____)

☐ Self-Employed ☐ Student ☐ Disabled ☐ Retired ☐ Other (_____)

FAMILY INFORMATION

FAMILY SIZE
_____

List family members in your household, including yourself.
Family is defined as "people related by birth, marriage, or adoption who live together"
**Attach additional page if needed.*

Name	Date of Birth	Relationship to Patient	Employer Name(s) – or- Source of Income	Total Gross Monthly Income (before taxes):
		SELF		

Financial Assistance Application Form – confidential (page 2)

INCOME INFORMATION

REMEMBER: All family members' income must be disclosed. Provide proof for every identified source of income.

Source of income includes, for example:
-Wages -Unemployment -Self-Employment -Worker's Compensation -Disability -SSI -Child/Spousal Support -Pension -FNS/SNAP -Retirement Distribution -Rental Income -Other (please explain): _____

Supporting Documentation (i.e., "proof of income") includes, for example:

- A "W-2" withholding statement for current year
- Current pay stubs from all employment (3 months)
- An income tax return from the most recent calendar year, including schedules (if applicable)
- Current bank statement reflecting deposit(s) for all other sources of income (3 months)
- PFMLA (Paid Family Medical Leave of Absence) deposit notification or payment statement
- Social Security Benefit award letter, Veteran Benefit award letter, Workers Compensation (L&I) award letter
- Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance
- Forms approving or denying unemployment compensation
- Written statements from DHS or other State Agency
- Retirement, Pension or Annuity Payment award letter
- Self-employment income tax forms, including schedules with Profit & Loss statement

If you have no income, you may submit a written and signed attestation explaining your circumstances.

MONTHLY HOUSEHOLD EXPENSE INFORMATION

We use this information to get a more complete picture of your financial circumstances.

Rent/Mortgage	$ _____	Other Debt/Expenses	
Medical or Prescription	$ _____	_____	$_____
Medical Insurance Premium(s)	$ _____	Other Debt/Expenses	
Utilities	$ _____	_____	$_____

ADDITIONAL INFORMATION

Please attach additional page(s) if there is other information about your current financial circumstances that you would like us to know, such as; a significant financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Healing Hands Medical Clinic may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I have given is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person(s) Applying **Date**

Mail, Fax, or Email your application with all supporting documentation to:
Healing Hands Medical Clinic; ATTN: Patient Financial Assistance, 530 E Hunt Hwy, Suite 108-485, San Tan Valley, AZ 85143 or Email: billing@healinghandsmc.org
To receive in-person assistance: Call 480-442-5863 to schedule an appointment