Financial Assistance Application Form

atlanta neuroscience institute

○ **New Patient**
☐ **Office Visit** ☐ **Procedure**

○ **Established Patient**
☐ **Office Visit** ☐ **Procedure**

Failure to provide documentation will be considered an incomplete application

SCREENING INFORMATION

Do you need an interpreter? ○ **Yes** ○ **No** *If Yes, list preferred language:*

Does the patient currently have health insurance? ○ **Yes** ○ **No**

Does the patient receive state public services such as TANF, Basic Food, or WIC? ○ **Yes** ○ **No**

Services Covered: Clinical Visit, MRI, EMG, EEG, Botox **Please note:** Laboratory work is not covered.

- **Your Account must be in good standing with ANI before applying for Financial Assistance.**

Please Note

- Completed applications:please email to financialassistance@atlneuroinstitute.org

- We cannot guarantee that you will qualify for financial assistance, even if you apply. If services are rendered, you will be responsible for fees
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.
- NO Same day approvals

PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Middle Name	Patient Last Name	
○ Male ○ Female	Medical Record No. (MRN)	Patient Birth Date	Patient Social Security No. (optional)

Mailing Address

City State Zip Code

Area Code Phone Numbers

( ) _____

( ) _____

Email address:

Employment Status:

○ **Employed** (date of hire):
○ **Self Employed** ○ **Student** ○ **Disabled** ○ **Retired** ○ **Other:**

○ **SSDI/SSI**
○ **Unemployed** (how long unemployed):

FAMILY INFORMATION

Please provide a comprehensive list of all family members residing in your household, including yourself, at the time of application..

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	Employer(s) name or source of income.	Total gross monthly income (before taxes)	Also applying for financial assistance?
					○ **Yes** ○ **No**
					○ **Yes** ○ **No**
					○ **Yes** ○ **No**
					○ **Yes** ○ **No**

All adult family members' income must be disclosed. Sources of income include, for example: - Wages - SSI/SSDI - Unemployment - Self-employment - Worker's compensation - Disability - Child/spousal support - Work study programs (students) - Pension - Retirement account distributions - Other (*please explain)*

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INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application. Incomplete applications will not be processed.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. Please provide at least two identified sources of income.

Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (3 months); or
- Checking & Savings Accounts (3 months); or
- Last year's income tax return

Income Information Continuation

The following examples of proof of income requires most 3 recent bank statements.

- Letter of termination from employers or others (letter of support) stating your current financial situation and circumstances if you have no proof of income; or
- Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance; or
- Forms approving or denying unemployment compensation

MONTHLY EXPENSE INFORMATION (Please attach another page to list out other debts, if needed.)

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

Rent/Mortgage $ _____ Medical Expenses $ _____

Insurance Premiums $ _____ Utilities _____

Other Debt/Expenses $ _____ *child support, loans, medications, other)* $ _____

ASSET INFORMATION (not considered for financial assistance qualification but is used for other programs)

Current Checking Account Balance
$ _____

Current Savings Account Balance
$ _____

Does your family have these other assets? **Please check all that apply**

☐ Stocks ☐ Bonds ☐ 401K ☐ Health Savings Account(s) ☐ Trust(s)

☐ Property (excluding primary residence) ☐ Own a business

Financial Assistance Application Form – Continued

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Additional Information
Please provide other information about your current financial situation that you would like us to know, such as financial hardship, seasonal or temporary income, or personal loss

PATIENT AGREEMENT
I understand that Atlanta Neuroscience Institute may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans. I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

Name of Person Applying

Date

Office Use only:

Approved by:

Financial Assistance Type:

Date approved through:

Duration of financial assistance: