AIS Healthcare®

FINANCIAL ASSISTANCE PROGRAM APPLICATION

This Financial Assistance Program Application must be completed and returned to AIS Healthcare Financial Services with documented proof of your reported income for the current year or the year for which you are requesting assistance. Documents can include:

- 1040 tax return (preferred) **or**
- Social Security award letter, 2 monthly statements from Social Security, SSI, Disability, Pension, Retirement **or**
- (2) Two recent complete bank statements (all pages to include blank pages) **or**
- (2) Two recent employer paycheck stubs or unemployment check stubs **or**
- Medicaid or other state-funded medical assistance forms

All financial documents must be completed with a legible name and not be altered.

The Financial Assistance Program Application and proof of income must be renewed annually.

Patient name: _____ Cell phone: _____

Complete mailing address: _____

Email address: _____

HOUSEHOLD MEMBERS/DEPENDENTS

Provide name and age of all household members and other dependents:

Dependent name 1: _____ Age: _____

Dependent name 2: _____ Age: _____

Dependent name 3: _____ Age: _____

If there are more than 3 people (besides the applicant) living in the household, please include dependent(s) name and age in the Additional Information Section on the second page of this Application.

FINANCIAL INFORMATION

Fill in spaces that apply. All information provided represents the total income for patients and household members/dependents listed above.

1. Monthly wage income (Before taxes): ..... _____

2. Monthly untaxed income (Non-taxable–include Social Security, SSI/Disability, & child support): _____

3. Monthly other income (Before taxes–include pension and other income sources): ..... _____

Monthly income total: (Add lines 1, 2, and 3 for a combined total): ..... _____

For additional consideration, provide your Household Qualifying Expenses on the back of this form.

I certify that the financial information contained in this worksheet is true and accurate and that this application is made to enable AIS Healthcare to evaluate my eligibility for financial assistance to help reduce my future out-of-pocket medical expenses. I give consent and authorize AIS Healthcare to make all inquiries necessary to verify information provided herein. This information includes, but is not limited to, direct contact with my employer(s), credit holder(s), credit reference(s), or financial institution(s). If any of the information that I have provided proves untrue, I understand that AIS Healthcare may reevaluate my financial status and take necessary action to collect any sums I owe.

Patient name: _____

Signature: _____ Date: _____

Advancing quality. Improving lives.

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HOUSEHOLD QUALIFYING EXPENSES (HQEs)—MONTHLY AMOUNT (Documentation not required)

Housing (Monthly Mortgage/Rent Payment, Insurance, Taxes) ..... $ _____

Utilities (Phone, Gas, Electric, Water, Trash) ..... $ _____

Groceries ..... $ _____

Car (Monthly Payment, Insurance, Gas) ..... $ _____

Insurance Premiums (Life, Medical, Dental, Vision) ..... $ _____

Other Medical Bills ..... $ _____

Medications ..... $ _____

Child Care ..... $ _____

Other (Loans, Credit Cards, Student) ..... $ _____

Total Household Qualifying Expenses (Add all of the above amounts) ..... $ _____

ADDITIONAL INFORMATION

Any additional information to be considered with this application: _____

_____

Financial Assistance Application Form Instructions

Below is additional information to assist you in completing the application.

Patient Information
- Complete all patient demographic information

Dependents
- Provide the list of all household members, to include spouse and other dependent names and ages

Financial Information
- Include financial information for applicant, spouse, and dependents in household
- All pages of a financial document that has more than 1 page must be submitted
- Supply requested number of documents for proof of income.
- Do not send original documents

  ALL documents must be legible. Financial documents cannot be redacted or altered **except** for your Social Security Number or bank account number.

Additional Information
- If you do not have any income, include a separate explanation of your circumstances and proof of income from whoever is supporting you financially
- Print name
- Sign and date the application form

Returning the Application and Supporting Documentation
- You can email, fax, or mail the completed application and supporting documentation to: Email: FCT@aiscaregroup.com; Fax: 888.298.0092; Mail: 623 Highland Colony Parkway Suite 100, Ridgeland, MS 39157
- All applications returned without the appropriate information or insufficient documentation will be considered incomplete and not processed until all information is received

Assistance
- If you have questions or need assistance with completing this application, please contact us at 1.877.299.4371, Option #2

What's Next
- We will notify you of the final determination of eligibility by mail within 5 to 7 business days of receiving a completed financial application and supporting documentation