PALLITUS
HEALTH PARTNERS

Financial Assistance Application

Patient Name: _____ **Patient ID:** _____

Dependents: (Provide 50% or more of their support)

Full Name	Relationship	Age	Total in Household (Including Pt.)

Monthly Source of Income	Patient/ Legal Guardian Monthly Gross Income	+	Spouse/Other Monthly Gross Income	=	Total Family Monthly Income	x12=	Annual Gross Income
Wages/Self Employment, Child Support, Alimony		+		=		x12=	
Social Security		+		=		x12=	
Pension, Dividends, Interest, Rental Income		+		=		x12=	
Unemployment, Workers' Compensation, VA Benefits		+		=		x12=	
TOTAL							$

***Please attach proof of income. This application cannot be processed without supporting documentation.**

I have applied for or will apply for state medical assistance. ☐ Yes ☐ No

I certify that the information provided in this application is correct and true to the best of my knowledge.

_____ _____

Patient / Legal Representative Signature **Date**