Application for Financial Assistance

Patient Name:

_____

Account #:

_____

Address:

_____

City: _____ State: _____ Zip: _____

Account Balance: _____ Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

Dependents:

_____

Please write a detailed description of your circumstances.

Attach the following documents

1. Last two paycheck stubs from all employed household members.
2. Last year's federal income tax forms and W – 2 statements.
3. Last 3 months of bank statements.

4. Unemployment proof or denial paperwork
5. Approval or denial of Medicaid

I attest that the information provided is true and complete to the best of my knowledge. I give authorization to Orthopaedic Associates of Grand Rapids to confirm any information listed on this form. I give my consent to all creditors and financial institutions to release information about my financial situation to Orthopaedic Associates of Grand Rapids. I understand that in the event my account is pursued for collection any discount that may have been given as a result of this verification will be revoked by Orthopaedic Associates of Grand Rapids,

Signature: _____ Date: _____

Witness Signature: _____ Date: _____