



Financial Assistance Application

This is an application for financial assistance at OVP Health Care, Inc. You may qualify for financial assistance based on your family size and income. Assistance is awarded if you meet the financial assistance guidelines which includes your household income is 200% or less of the federal poverty level.

Please provide the below requested information

Date ___/___/___

Patient Name _____ Male _____ Female _____

Date of Birth ___/___/___

Social Security Number _____

Address _____

Phone _____ Cell _____

Email Address _____

Insurance ___ Yes ___ No, If Yes, Insurance name _____

Insurance ID# _____

Do you receive Public assistance? If so, what programs _____

Employer _____

Family Information

Number of family members living in the same home _____

Gross Wages or income from any source _____

Please provider a copy of the following:

W-2 or Current pay stub

Last year's income taxes

PT Name _____ DOB ___/___/___

I understand that OVP Health may verify information provided 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 all services provided.

Patient Signature _____ Date _____