OVP HEALTH

Financial Assistance Application

This is an application for financial assistance at OVP HEALTH. 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: _____

Gender Assigned at Birth: _____ Personal Pronouns: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

Phone Number: _____ 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 all sources in the household: _____

Number of individuals in the household that have income: ____

Please provide a copy of the following for all members of the household:

W-2, *Current pay stub*, *Last year's income taxes*, *Government Assistance Statement*

Patient Name: _____ Date of Birth: _____

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: _____