Account Number: _____

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name: _____
Last First Middle Initial

Responsible Party

Last Name		First Name	
Date of Birth	SSN	Marital Status	
Address:	City	State	Zip
Home Phone		Mobile Phone	
Employer		Employer Phone	
Monthly Gross Income	$	Monthly Net Income	$
Other Income (Source and Amount)			

PLEASE SUPPLY VERIFICATION OF INCOME BY ATTACHING A COPY OF YOUR CHECK STUB.

Spouse Information

Skip to next section if not applicable

Last Name		First Name	
Date of Birth	SSN	Marital Status	
Address:	City	State	Zip
Home Phone		Mobile Phone	
Employer		Employer Phone	
Monthly Gross Income	$	Monthly Net Income	$
Other Income (Source and Amount)			

PLEASE SUPPLY VERIFICATION OF INCOME BY ATTACHING A COPY OF YOUR CHECK STUB.

Child Dependent Information

Skip to next section if not applicable

Full Name of Dependent Children	Age	Full Name of Dependent Children	Age
1.		3.	
2.		4.	
5.		6.	

Confidential Financial Information

Of Responsible Party

Please provide an <u>average</u> of your monthly living expenses in the following categories.

Housing	$	Utilities	$	Vehicle	$

Health Insurance	$	Food	$	Phone	$
Child Care	$	Other Expenses	$		

Confidential Financial Information
Continued

Financial Obligations

Auto Loan?	Yes ☐	No ☐	Monthly Payment	$
Home Loan?	Yes ☐	No ☐	Monthly Payment	$
Other				

Other Medical Bills

List all medical bills owed:

Medical Expense	Balance Due	Monthly Payments
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

Please attach an additional sheet if needed

If you have little or no income, please write a statement explaining how your monthly living needs are met. If you receive assistance from family and/or friends, please have them write a statement as to what help they have given you during the last year.

In order to process your request for assistance you need to supply an amount you can pay on a monthly basis. Salem Radiology Consultants offers up to a 40% discount and you will be responsible for the balance.

All accounts must be paid in full within 12 months from the date of service. Minimum monthly payment is $25.00. Monthly payments for balances larger than $300.00 will be split into 12 equal monthly payments. $_____

If for any reason you do not make payment, any discount you have been granted will be reinstated before the account is turned to a collection agency.

I, _____, certify that the information provided is true and accurate to the best of my knowledge. I have read and agree to the conditions provided above.

Signature	Date
Spouse Signature	Date

Mail Form and Documentation to:
Salem Radiology Consultants
P.O. Box 12989
Salem, OR 97309