Request for Determination of Eligibility for Free Care

Aryana health care foundation

PATIENT NAME		DATE OF BIRTH	SOCIAL SECURITY #
ADDRESS			
PHONE NUMBER		DATE OF SERVICE / ACCOUNT #	
RESPONSIBLE PARTY	ADDRESS		SOCIAL SECURITY #
ADDRESS			
MARITAL STATUS	INSURANCE NAME, IF ANY		
EMPLOYER	OCCUPATION		RATE OF PAY

SIZE OF FAMILY:_____

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT

Income: *(List all income for yourself, spouse and other dependents, from any of the following:)*

		Monthly
Wages	☐	$_____
Self-Employment	☐	$_____
Social Security	☐	$_____
Unemployment	☐	$_____
Workers Comp	☐	$_____
Alimony / Child Support	☐	$_____
Pensions	☐	$_____
Rental Prop Income	☐	$_____
Dividends & Interest	☐	$_____
Public Assistance	☐	$_____
Lottery Winnings	☐	$_____
Other	☐	$_____
MONTHLY TOTAL		$_____

Continued ➔

Proof of income is required. Please provide the following:

_____: If self-employed, three month Profit and Loss statement and most recent tax return

_____: Income Tax Forms, valid January Through April **only**

_____: 4 most recent pay stubs, including year-to-date totals from all employers

_____: Written explanation of current financial situation - Notarized

_____: Denial notice from the Department of Human Services

_____: or other proof of your income

I affirm that the given information, including income, is true and correct to the best of my knowledge. I understand that the information which I submit concerning my annual income and family size is subject to verification by The Aryana Health Care Foundation. I also understand that if the information which I submit is determined to be false, such determination will result in a denial of providing services as Free Care, and that I will be liable for charges for services provided.

Signature of Person Making Request	Relationship to Patient	Date of Request

For patients completing this application to justify lower monthly payments, please include the following information related to expenses.

Monthly Expenses: List all monthly expenses that apply.

Housing (mortgage/rent):	$_____
Property Taxes:	$_____
Credit Cards/Loans:	$_____
Auto Loans:	$_____
Phone:	$_____
Electricity:	$_____
Water / Sewer	$_____
Child Care:	$_____
Fuel:	$_____
Health Insurance:	$_____
Insurance:	$_____
Food:	$_____
Other:	$_____

Send completed form to:	**Aryana Health Care Foundation** 20398 Blauer Dr., Saratoga, CA 95070	**Phone:** (408) 359-1061

For Office Use Only:

150% FPL / 100% _____

175% FPL / 100% _____

200% FPL / 50% _____

225% FPL / 25% _____

Financial Counselor	Date
Approving Signature	Date