MLK Community Healthcare
Financial Assistance Application

Patient Name _____ Patient Account Number _____

Telephone Number _____ Birth Date (Month/Date/Year) _____

Spouse Name _____ Birth Date (Month/Date/Year) _____

A. *Income:* Please provide the income for each of the following persons in your household.

		Circle One			Circle One
Patient	$_____	/Hr /Wk /Month /Year	Patient's Guardian (if patient is a minor)	$_____	/Hr /Wk /Month /Year
Spouse	$_____	/Hr /Wk /Month /Year	Patient's Guardian (if patient is a minor)	$_____	/Hr /Wk /Month /Year

Total Yearly Family Income: $_____

B. *Family Members:* Please provide the number of persons (number of dependents listed on tax return).. _____

C. *Income Verification:* Please provide the following types of documentation to verify your income.

- IRS Form W-2
- Paycheck Remittance
- Tax Return
- Bank Statements
- Employer Verification
- Unemployment Compensation Determination Letters
- Proof of Participation in a Government Assistance Program other than AFDC, Medical, CCS and food stamps
- Social Security or Workers' Compensation Determination Letters
- RSDI letter
- Other, Please Describe:

_____

_____

_____

- If you are unable to provide one of the sources of income documentation listed in Section C, please explain why this information is not available:

_____

_____

_____

_____

I understand that MLK Community Healthcare (MLKCH) may verify the financial information contained in this Financial Assistance Application ("Application") in connection with MLKCH evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I am aware that falsification of information on this Application may result in denial of entitlement to financial assistance.

_____ Date _____

Signature of Patient or Responsible Party

_____ Date _____

Employee Signature if any part of Financial Assistance Application Completed by an Employee

Policy Ref # MLKCMG-1057 (02/02/2024)