Van Buren Clinic - RHC
Cumberland Family Care, PC
Application Form for Financial Assistance/Financial Hardship

This form only applies to uninsured patients. Please complete the following information if you are applying for a sliding fee discount for medical services or requesting free services. Information provided should list current income or income provided from most recent Tax Returns. Information on number of people living in household should include everyone living in the home, not just relatives. In addition to the Financial Hardship Application, please bring the most recent copy of your W-2 or Tax Return (if you have one), and proof of your current residence.

Patients are responsible for informing the receptionist if financial status changes during the course of care. Cumberland Family Care, PC uses the recognized poverty guidelines as updated by the Department of Health and Human Services to determine financial hardship to receive significantly discounted medical care or free of charge. If such application is not approved, patients may request special payment arrangements in addition to discounted fees.

Name	Name of Employment/Retired/Unemployed/Veteran
Address	City State Zip
Phone	Last four digits of SSN

To apply for the Sliding Fee Discount or request medical care Free of Charge:

List all income sources:	Self	Others in the Home	Other	Total
Gross wages, salaries, tips, etc.	$	$	$	$
Soc. Sec. and/or disability, pension, annuity, veterans benefits, military income or retirement	$	$	$	$
Alimony and/or child support	$	$	$	$
Income from self employment, dependents or other people living in your household	$	$	$	$
Rent, Interest, dividends, or other income	$	$	$	$
Total Income	$	$	$	$

Add across the **Total Income** Line for Grand Total $_____

☐ **Please (√) the box if you are requesting to receive care Free of Charge.**

I certify that the above information is correct and understand that Cumberland Family Care, PC-Van Buren has the right to verify all information and request additional documents if necessary.

_____ _____

Patient's Signature Date

For Office Use Only

Information Verified: Yes No Effective Date:_____

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Approved by: **Billing Initials:**

Valid Through: **Documentation in eHR patient record:** **Initials:**

Reviewed: 01.01.23