Financial Assistance Application

This is an application for financial assistance at OVP Health Care, Inc. 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_____ Male_____ Female_____

Date of Birth ____/____/_____

Social Security Number _____

Address_____

Phone_____ 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 any source_____

Please provider a copy of the following:

W-2 or Current pay stub

Last year's income taxes

PT Name _____DOB___/____/____

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_____