AD | ANESTHESIA DYNAMICS
accountservices@anesthesiadynamics.com
888-851-4642

FINANCIAL ASSISTANCE APPLICATION

DATE OF APPLICATION: _____

1. FAMILY INFORMATION (PLEASE PROVIDE NAMES OF ALL PEOPLE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE) - PLEASE PRINT ALL INFORMATION-			
Last Name	**First Name**	**Middle Initial**	**Medical Record Number**
Last Name	**First Name**	**Middle Initial**	**Medical Record Number**
Last Name	**First Name**	**Middle Initial**	**Medical Record Number**

If the patient is a minor, please list parent(s)/guardian(s) as applicant and co-applicant.

2. APPLICANT (GUARANTOR) INFORMATION

RELATIONSHIP TO PATIENT
☐ **Self** ☐ **Spouse/Domestic Partner** ☐ **Parent** ☐ **Other**

MARITAL STATUS
☐ **Single** ☐ **Married/Domestic Partner** ☐ **Divorced** ☐ **Separated**

IF YOU MARKED YES TO MARRIED OR DOMESTIC PARTNER: PLEASE COMPLETE SECTION 3

Last Name	**First Name**	**Middle Initial**	**U.S. Citizen** ☐ Yes ☐ No

Date of Birth	**No. of Dependents** (other than self& co-applicant)	**Ages of Dependents**	**Home Phone** ( )

Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**

Current Employer	**Street Address, City, State**	**Position**

*** If you are not working, how long have you been unemployed?**

3. CO-APPLICANT (GUARANTOR) INFORMATION

RELATIONSHIP TO PATIENT
☐ **Spouse/Domestic Partner** ☐ **Parent** ☐ **Other** _____

Last Name	**First Name**	**Middle Initial**	**U.S. Citizen** ☐ Yes ☐ No

Date of Birth	**No. of Dependents** (don't include those claimed by co-applicant)	**Ages of Dependents**	**Home Phone** ( )

Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**

Current Employer	**Street Address, City, State**	**Position**

*** If you are not working, how long have you been unemployed?**

4. OTHER COVERAGE QUESTIONS: -- (All answers pertain to the patient)

		Check appropriate answer
1.	Does the patient have health insurance? If yes, please provide the following information: Health Insurance Name:_____ Subscribers Name:_____ Members/Patients Identification Number:_____ Group Number:_____ Group/Employer Name:_____ Effective Date:_____ Health Insurance Telephone Number:_____	☐ Yes ☐ No
2.	Is the patient eligible for a state medical assistance program? If yes, please provide the following information: Name of program:_____ County:_____ Patient Identification Number:_____	☐ Yes ☐ No
3.	Is the patient being treated for injuries covered by Workers Compensation? If yes, please provide the following information: Name of Work Comp Carrier:_____ Adjusters Name:_____ Adjusters Phone Number:_____ Injury Date:_____ Claim/Case Number:_____	☐ Yes ☐ No
4.	Is the patient being treated for injuries covered by Third Party Liability such as an Auto Insurance Company? If yes, please provide the following information: Name of Auto insurance or Attorney:_____ Auto Insurance or Attorney Phone Number:_____ Injury Date:_____ Claim/Case Number:_____	☐ Yes ☐ No
5.	Is the patient a Victim of Crime? If yes, please provide the following information: Date of injury? _____ Name of Case Worker:_____ Case Workers Phone Number:_____ Case Number:_____	☐ Yes ☐ No

5. INCOME INFORMATION

Monthly Income Sources	**Applicant**	**Co-Applicant**	**Combined Monthly Income (Applicant + Co-Applicant)**
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other[s] use these spaces	$	$	$
	$	$	$
		Total Combined Monthly Income	$

6. IF YOU DO NOT HAVE MONTHLY INCOME, PLEASE EXPLAIN HOW YOU TAKE CARE OF YOUR MONTHLY EXPENSES. USE ADDITIONAL PAGES IF NECESSARY

7. SIGNATURE

I certify that all information is valid and complete and hereby authorize Stanford Hospital & Clinics to request and/or verify any of the above information as deemed necessary.

Applicant **Date** **Co-Applicant** **Date**

_____ _____ _____ _____

Return completed application to: **Patient Financial Assistance**

accountservices@anesthesiadynamics.com