FINANCIAL ASSISTANCE APPLICATION

DATE OF SERVICE: _____ EMAIL ADDRESS: _____

PATIENT OR APPLICANT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ MARITAL STATUS: _____ SSN: _____

THE FOLLOWING <u>MUST</u> BE COMPLETED FOR FINANCIAL ASSISTANCE CONSIDERATION.

(List spouse and dependent children under 18 years, living in the household and their dates of birth)

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	TOTAL GROSS INCOME IN THE 3 MONTHS PRIOR TO THE DATE OF SERVICE	TOTAL GROSS INCOME IN THE 12 MONTHS PRIOR TO THE DATE OF SERVICE	SOURCE OF INCOME EMPLOYER NAME (STATE IF YOU ARE A COLLEGE STUDENT)
	SELF				

1. **IF YOU REPORTED ZERO TOTAL INCOME, HOW ARE YOU BEING SUPPORTED?** _____
2. WHAT STATE DID YOU RESIDE IN AT THE TIME OF YOUR VISIT? _____
3. HAVE YOU APPLIED FOR MEDICAID OR ANY OTHER COUNTY ASSISTANCE? ☐ NO ☐ YES (DATE/STATE _____)
4. DID YOU HAVE HEALTH INSURANCE ON THE DATE OF SERVICE? ☐ NO ☐ YES (PROVIDE COPY OF CARD WITH THIS APPLICATION)

FOR INCOME LISTED ABOVE YOU MUST PROVIDE ONE OF THE FOLLOWING FOR EACH MEMBER OF THE HOUSEHOLD:

(please check items received)

- ☐ COPY OF 2 MONTHS OF PAYSTUBS
- ☐ UNEMPLOYMENT = BENEFIT LETTER OR BANK STATEMENT
- ☐ SOCIAL SECURITY = BENEFIT LETTER OR BANK STATEMENT
- ☐ SELF EMPLOYMENT = COMPLETE TAX FORMS INCLUDING SCHEDULE C
- ☐ CHILD SUPPORT = COURT ORDERED DOCUMENT
- ☐ OTHER= PROOF OF ANY OTHER INCOME SUCH AS DIVIDENDS, INTEREST, RENTAL INCOME
- ☐ DISABILITY =BENEFIT LETTER OR BANK STATEMENT

CERTIFICATION: *BY SIGNING THIS DOCUMENT, I AFFIRM THE ANSWERS ON THIS APPLICATION ARE TRUE. SHOULD A SUBSEQUENT REVIEW OF AN INDIVIDUAL'S FINANCIAL ASSISTANCE APPLICATION REVEAL THAT INFORMATION PROVIDED BY THE INDIVIDUAL WAS EITHER INCORRECT OR FRAUDULENT, THE DECISION TO PROVIDE FINANCIAL ASSISTANCE MAY BE REVERSED AND THE RESPONSIBLE PARTY WILL BE BILLED. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY MY PROVIDER, INCLUDING CREDIT REPORTING AGENCIES, AND SUBJECT TO REVIEW BY FEDERAL AND/OR STATE AGENCIES AND OTHERS AS REQUIRED.*

PATIENT SIGNATURE: _____ **DATE:** _____

APPLICANT OR REPRESENTATIVE SIGNATURE: _____ **RELATIONSHIP:** _____ **DATE:** _____
(IF NOT PATIENT)

MAIL OR EMAIL COMPLETED APPLICATION AND DOCUMENTATION TO:

CompuNet Clinical Laboratory
2308 Sandridge Dr
Moraine Ohio 45439
cclbillingweb@compunetlab.com

Last Revision:09/2026