GATEWAY
DIAGNOSTIC IMAGING

Gateway Diagnostic Imaging
Financial Assistance Application

Patient Account Number

Patient Name (Last, First, MI) ______ Social Security Number

Patient's Residential Address ______ City ______ State ______ Zip Code ______ County

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

Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Divorced ☐ Widowed

Spouse's Name ______

Employed ☐ Yes ☐ No

Patient's Employer______

Telephone # ______

Employed ☐ Yes ☐ No

Spouse's Employer ______

Telephone # ______

Are the GDI facilities you received services at the closest in network facilities to your primary residence? ☐ Yes ☐ No

If no, were the closest facilities unable or unwilling to provide your care? ☐ Yes ☐ No

*****If unemployed, please include the previous employer's name and telephone number*****

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

Patient ☐ Full Time ☐ Part Time - Hours/Week =______
$______ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$______ **Additional Income**

Spouse ☐ Full Time ☐ Part Time - Hours/Week =______
$______ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$______ **Additional Income**

Total Household Income $ ______

Please complete only if patient is a minor (if not leave blank)

Patient's Father ☐ Full Time ☐ Part Time - Hours/Week =______
$______ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$______ **Additional Income**

Patient's Mother ☐ Full Time ☐ Part Time - Hours/Week =______
$______ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$______ **Additional Income**

Total Household Income $ ______

B. ***Income Verification:*** Please provide verification ***(send only copies, no original documentation)*** for all sources of household income (acceptable documentation listed below). Check attached documents:

☐ Paycheck Remittance
☐ IRS Form W-2
☐ Bank Statements
☐ Employer Verification
☐ Tax Return
☐ Other (describe below)
☐ Credit Inquiry (completed by GDI)
☐ Governmental Assistance (food stamps, CDIC, Medicaid, TANF)
☐ Social Security, Workers Compensation or Unemployment Compensation Determination Letters

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

______

C. ***Family Members:*** **Please provide the total number of people in the patient's household.**
(This number should only include the patient, patient's spouse, and the patient's dependents)

D. ***Assets and Other Resources:***

Do you have any assets or other resources available to you? ☐ Yes ☐ No If Yes, current amount available: $______
(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)

Do you have medical insurance? ☐ Yes ☐ No If Yes, please list provider name: ______

Do you have a Health Savings Account or Flexible Spending Account? ☐ Yes ☐ No If Yes, current amount available: $______

I understand Gateway Diagnostic Imaging ("GDI") may verify the financial information contained in this Financial Assistance Application ("Application") in connection with GDI's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize GDI to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation ofinformation on this Application may result in denial of financial assistance.

I further understand that some physicians and providers may not be employees of GDI. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

Signature of Patient or Responsible Party ______ **Printed Name** ______ **Date** ______

For GDI Use Only

☐ Application information obtained by GDI Employee in person or over the phone, no patient signature required.

Electronic Signature of GDI Employee or Representative ______ Date ______

Notes Regarding Income Verification/Number in the Household:

☐ Patient is part of community care program Program Name______ First Statement Date: ______