

<b>PLEASE ENTER THE ACCOUNT NUMBER(S) LISTED ON YOUR STATEMENT(S):</b>		<b>PATIENT IDENTIFICATION NUMBER (PID):</b>	
<b>PATIENT DEMOGRAPHICS</b>			
Patient's Name (Last, First, MI)		Social Security Number	
Patient's Residential Address (Street, City, State, Zip Code)		Date of Birth (Month/Date/Year)	
Patient's Phone	Marital Status <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Spouse's Name	
<b>EMPLOYMENT **Applications for minor patients require total household income**</b>			
<b>PATIENT OR RESPONSIBLE PARTY EMPLOYMENT</b> <i>If the patient is a minor: mother, guardian, or stepparent</i>		<b>SPOUSE OR OTHER RESPONSIBLE PARTY EMPLOYMENT</b> <i>If the patient is a minor: father, guardian or stepparent</i>	
<b>Employment Status</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed - <i>Please include the previous employer's name and telephone number.</i>		<b>Employment Status</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed - <i>Please include previous employer's name and telephone number.</i>	
<b>Employer</b>			
<b>Employer Phone Number</b>			
<b>Hours Worked Per Week</b>	<b>Frequency</b> <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	<b>Hours Worked Per Week</b>	<b>Frequency</b> <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
<b>Frequency</b>	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually		
<b>Income Earned</b> \$	<b>Income Earned</b> \$		
<b>Additional Income</b> \$	<b>Additional Income</b> \$		
<b>Patient's Total Household Income: \$ _____ (Total of all income listed above)</b>			
<b>Income Verification:</b> <b>Please provide verification (send only copies, no original documentation) for all sources of household income.</b>		<input type="checkbox"/> Paycheck Remittance <input type="checkbox"/> Employer Verification <input type="checkbox"/> Credit Inquiry (completed by GDI) <input type="checkbox"/> IRS Form W-2 <input type="checkbox"/> Tax Return <input type="checkbox"/> Governmental Assistance (food stamps, CDIC, Medicaid, TANF) <input type="checkbox"/> Bank Statements <input type="checkbox"/> Social Security, Workers, Compensation or Unemployment Compensation Determination Letters <input type="checkbox"/> Other: _____	
If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:			
<b>FAMILY MEMBERS:</b> Please provide the total number of people in the patient's household. This number should only include the patient, the patient's spouse, and the patient's dependents. <input type="text"/>			
<b>ASSETS AND OTHER RESOURCES</b>			
Do you have any assets or other resources available to you? (Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, current amount available: \$ _____		Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please list insurance name: _____	
		Do you have a Health Savings Account or Flexible Spending Account? <input type="checkbox"/> Yes <input type="checkbox"/> 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 valuation 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 of information 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 _____	
<b>FOR HOSPITAL USE ONLY</b>			
<input type="checkbox"/> Application information obtained by GDI Employee in person or over the phone, no patient signature required. Signature of GDI Employee / Rep: _____ Date: _____		<input type="checkbox"/> Patient is part of community care programs Name of Program: _____	