Application for Financial Assistance

Application Instructions

Please complete all fields on the application and sign where indicated. Please provide all types of **gross family** income as indicated below. Proof of your income should also be provided in the form of income tax return, pay stubs, etc.

If you have questions, please contact InfuSystem at 1-833-570-4737.

All information provided is confidential and used only for the purpose of determining financial assistance.

Today's Date: ____/____/____ **Account#: _____**		
Patient Information		
Patient Name:		Patient Date of Birth: ____/____/____
Patient Address:		
City:	State:	Zip:
Patient/Responsible Party Phone Number:		
Email Address *(*If you would like to receive communication regarding this application via email)*:		
Number of Dependents, Including Yourself Living in Your Household:		

Income Information

Provide the following information for you, significant other and dependents living in the home.

Income Source	Total for 3 months prior to first treatment date	Total for 12 months prior to first treatment date
Wages/Self Employment	$	$
Social Security	$	$
Pension, Dividends, Interest, Rental Income	$	$
Unemployment, Workers' Compensation	$	$
Child Support	$	$
Other	$	$

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to determine my ability to pay for services provided by InfuSystem.

Signature:_____ Date:_____/_____/_____