Solvista Health Financial Assistance Application

Patient Information			Today's Date: / /		
First Name:	Middle:	Last:	Other names:		
Home Address:		City:	State:	Zip:	
Mailing Address:		City:	State:	Zip:	
Home Phone #: ( ) -		Home Phone #: ( ) -			
Date of Birth: / /					

Household Size		
Name	**Date of Birth**	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. You must verify your income at least every year.
Family size and annual income will be used to determine your eligibility and calculate your discount.

Household Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	$

Acknowledgement
I hereby attest that I can access and view the sliding fee scale and that the information I have provided is true and correct. I understand providing false or misleading information may disqualify me immediately and I may become financially responsible. I agree to work with Solvista to provide any additional information to help make a determination. I understand that any assistance provided is only available for one year or when my circumstances change, whichever occurs sooner.

Date: __________________________ Name (Print):____

Signature: ____