Financial Assistance Application

Medical Faculty Associates Financial Counselor's Office
2150 Pennsylvania Ave. NW, Room G-206, Washington, DC 20037
202-741-3560 Customer Service (Billing Only)

Date: _____ Patient Account #_____

Patient Name: _____ Birthdate: ___/___/___
(Please print LAST NAME, FIRST NAME, MI)

Address: _____

City& State: _____ Zip Code: _____

Home Telephone: (___)_____ Cell Phone: (___)_____

Social Security#: _____ Marital Status: _____

Dependents Listed on Federal Tax Form:

Name: _____ Age: ____ Relationship:_____

Name: _____ Age: ____ Relationship:_____

Name: _____ Age: ____ Relationship:_____

Name: _____ Age: ____ Relationship:_____

Name: _____ Age: ____ Relationship:_____

Please reference the date(s) of service that this request affects: _____
(Note: Approved requests are applicable for a 90-day period only. Applicant must reapply for future treatments and be considered based on your current financial status.)

Patient Employer:

Name: _____

Address: _____ City,State:_____

Work Phone# _____ How long have you worked here? _____

Spouse's Employer:

Name: _____

Address: _____ City,State:_____

Work Phone# _____ How long employed here? _____

Income and Expenses

All applications must be accompanied by income verification to include the items from below. Missing documents may result in a delay in considering your request.

Proof of Income-Please provide one of the following documents:

- Paystubs from the last 3 months **or;**
- An official income verification letter from your employer **or;**
- Your current taxes and W-2 forms **or;**
- If you are receiving assistance from the state, county or district, please provide a "Letter of Support" from the organization or agency that provides assistance.

Monthly Living Expenses

Rent	$_____
Food	$_____
Utilities	$_____
Transportation	$_____
Medical Expenses	$_____
TOTAL EXPENSES	$_____

Has the applicant ever applied or currently applying for Medical Assistance? YES NO

If you have applied, please provide Social Worker's Name and Phone Number

Name: _____ Phone: _____

I hereby certify that to the best of my knowledge, the information listed on this statement is true and represents a complete statement of my income and expenses at the time this application was submitted.

Applicants Signature: _____ Date: _____

Return this application to:	Medical Faculty Associates Business Office-Customer Service 2150 Pennsylvania Ave, NW **Room G-206** Washington, DC 20037 202-741-3501 Fax Number