National Cardiovascular Partners

CARDIAC CATH LAB of PHOENIX

Financial Indigent Application

Please complete the Financial Indigent Application and return
All forms and required documentation to:

1910 E. Thomas Road · Suite 101 ·
Phoenix, AZ 85016-7766 · Tel: 480.470.0003 · Fax: 480.470.0004

I, _____, do hereby declare that I do not have the means and unable to gather the resources to pay for the medical services provided to me by Cardiac Cath Lab of Phoenix I understand that any falsification of this statement will render any financial assistance that is provided to me null and void and I will be responsible for paying the balance in full.

I cannot pay my medical bill because (**please check all that apply**):

- ☐ **I have a long-term disability that prevents me from working.**
- ☐ **I am currently unemployed.**
- ☐ **I have no available liquid assets to pay this bill.**

I certify that the above information is true and accurate to the best of my knowledge. I also understand that failure to provide all the information requested above may be considered a disqualification from any financial relief under the program. I also understand that financial assistance is conditional and does not apply to any third parties related to my treatment. Cardiac Cath Lab of Phoenix retains the right to recover the full balance from any third party resources to the full extent of the law.

_____ _____

Patient/ Responsible Party Signature **Date**

All information relating to financial indigent requests will be kept confidential

Date: ____/____/_____
MRN #:

Patient Name:		**DOB: ____/____/_____**	**SS #:**
Address:			
City:	**State:**	**Zip:**	**Phone #: ( )**

Marital Status

Married? ☐ **Yes** ☐ **No** **If Yes, Spouse Name:**_____

Age:_____

Dependents in Household

(This includes children under 18 and all others claimed on your Tax Return)

Name **(First, Middle and Last Name if different than patient)**	**Age**

Patient Employment History

Unemployed? ☐ **Yes** ☐ **No** **If Yes, Date Last Employed: ____/____/_____**			
Employer Name:		**Contact Name:**	
Address:			
City:	**State:**	**Zip:**	**Phone: ( )**
Hourly Rate: $_____ **Hours Worked per Week: _____**			
Current Gross Income (Before Taxes) $_____ ☐ **Weekly** ☐ **Monthly** ☐ **Yearly**			

Spouse Employment History

Unemployed? ☐ **Yes** ☐ **No** **If Yes, Date Last Employed: ____/____/_____**			
Employer Name:		**Contact Name:**	
Address:			
City:	**State:**	**Zip:**	**Phone: ( )**
Hourly Rate: $_____ **Hours Worked per Week: _____**			
Current Gross Income (Before Taxes) $_____ ☐ **Weekly** ☐ **Monthly** ☐ **Yearly**			
Date: ____/____/_____			

MRN #:

Other Income

Other Income	Patient/Responsible Party	Spouse	Dependents
Social Security Benefits	$	$	$
Unemployment Benefits	$	$	$
Workman's Compensation	$	$	$
VA Benefits	$	$	$
Other (Please list below) Examples: stocks, bonds, 401K, pension, dividend/interest, alimony, child support, rental income, etc.			
	$	$	$
	$	$	$
	$	$	$
	$	$	$
Subtotal :	$	$	$
Total Family Income:	$		

Expenses

Expenses	Patient/Responsible Party	Spouse	Dependents
Mortgage/Rent	$	$	$
Utilities (water, electric, gas, phone, etc.)	$	$	$
Transportation	$	$	$
Medical Bills/Expenses	$	$	$
Credit Cards	$	$	$
Other (Please list below)			
	$	$	$
	$	$	$
	$	$	$
Subtotal:	$	$	$
Total Family Expense:	$		

Have you applied for MCD or any other State/County Assistance? ☐ **Yes** ☐ **No**

If Yes, Give Case Number: _____Date Applied: _____/_____/_____

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this procedure bill prior to completing this application.

_____ _____

Patient/Responsible Party Signature **Date**

The undersigned has reviewed the supporting documentation provided by _____ (the "Applicant/Patient") with the Clinical Director or other appropriate individual in order to determine the Applicant's eligibility under the National Cardiovascular Partners, LP Indigent Patient Policy.

_____
Facility Representative

_____
Facility

_____
Date

Attach the following supporting documentation (if applicable):

- **Proof of Income**
- **Prior year tax return, including schedules if applicable (if none filed, then a W-2 form, letter from employer and current bank statements)**
- **Current pay stubs for the last three months;**
- **Social security, disability or unemployment check or award letter**
- **State Medicaid decision/denial notice**
- **Other documentation supporting current financial condition**
- **Copies of all expenses listed on application**

**** Once all supporting documentation is reviewed it must be returned to patient/applicant.**