



**APPLICATION FOR FINANCIAL ASSISTANCE**

In order for Amberwell Health to process your application, all sections must be completed. Along with your application, please submit the following documents for all members of your household so we can verify your financial situation:

- Bank statements (last two months)
- Pay stubs (last two months)
- Most recent tax returns

**SECTION ONE: APPLICANT INFORMATION**  
Please complete all of the below information regarding demographics and insurance information

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ Email: \_\_\_\_\_

**SECTION TWO: ADDITIONAL HOUSEHOLD MEMBERS INFORMATION**  
Please provide the below information for all immediate family members who live in your home.  
For these purposes "family" includes the applicant, applicant's spouse, and all of their children under 18 (natural or adoptive).

Additional Family Member Name(s)	Date of Birth	Relationship to Applicant
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

**SECTION THREE: FINANCIAL INFORMATION**  
Please provide any income that members of your household receive.

Income Source	Current Monthly Gross Income - Applicant	Current Monthly Gross Income - Spouse/Other
Employment Income	_____	_____
All Other Income Sources	_____	_____

If there is no household income, please use this space to explain how you are being supported:

**SECTION FOUR: INSURANCE INFORMATION**  
Please provide your health insurance/medical coverage information, if applicable.

Name of Insurer: \_\_\_\_\_ Subscriber ID Number: \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay my medical expenses. I understand that the information provided may be verified, and I authorize Amberwell Health to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the medical bill(s). I grant Amberwell Health permission to contact me using any method provided on this application.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_