APPLICATION FOR CHARITY CARE

Please MAIL, or EMAIL the Completed Form AND Supporting Documentation To:

Radiation Business Solutions

1044 Jackson Felts Rd, Joelton, TN 37080

Financialassistance@radiationbusiness.com

For questions call: (907)–302–4845

Patient Information

Patient Name:	Radiation Center:
Address:	Birth date:
City, State, Zip:	
Email:	Phone:
Marital Status: ☐SINGLE ☐MARRIED/PARTNERED ☐DIVORCED ☐SEPARATED ☐WIDOWED	

Financial Information

GUARANTOR, SELF, SPOUSE AND DEPENDENTS CLAIMED ON TAXES	DATE OF BIRTH	RELATION TO PATIENT	MONTHLY NET INCOME	SOURCE OF INCOME

TOTAL MONTHLY NET INCOME: $_____

IF NO MONTHLY WAGES ARE LISTED, PLEASE EXPLAIN HOW YOU TAKE CARE OF YOUR LIVING EXPENSES:

IF UNEMPLOYED, PROVIDE THE DATE EMPLOYMENT ENDED: _____

HAVE YOU APPLIED FOR UNEMPLOYMENT OR COBRA? ☐YES ☐NO

ARE YOU CURRENTLY INSURED? ☐YES ☐NO

IF UNINSURED, HAVE YOU APPLIED FOR MEDICAID/DISABILITY? ☐YES ☐NO

IF YES, WHAT IS THE CURRENT STATUS: _____
WHAT IS YOUR CURRENT HOUSING STATUS? ☐ RENT ☐ OWN ☐ N/A

MONTHLY PAYMENT (RENT OR MORTGAGE): $_____
PLEASE LIST ANY OTHER MONTHLY EXPENSES (Utilities, Loans, Credit Cards, Premiums, etc.)

1. _____ Amount: $ _____

2. _____ Amount: $ _____

3. _____ Amount: $ _____

4. _____ Amount: $ _____

PROVIDE ANY OTHER INFORMATION SUPPORTING YOUR FINANCIAL POSITION, OR DESCRIBE ANY FINANCIAL HARDSHIPS:

PLEASE SUBMIT **COPIES** OF THE FOLLOWING DOCUMENTS IN SUPPORT OF THE INFORMATION PROVIDED ABOVE:

- **PAYCHECK STUBS**
- **FEDERAL INCOME TAX RETURN**
- **PROOF OF SOCIAL SECURITY OR GOVERNMENT BENEFITS** (letter or bank statement)
- **BANK STATEMENTS** FOR CHECKING and/or SAVINGS

I CERTIFY THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE, ACCURATE AND TRUE. I UNDERSTAND THAT FRAUDULENT OR MISLEADING INFORMATION WILL MAKE ME INELIGIBLE FOR FINANCIAL ASSISTANCE. I AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED BY AURORA TO VERIFY THE INFORMATION PROVIDED. SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, I AUTHORIZE AURORA TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBILITY FOR THAT FUNDING.

APPLICANT SIGNATURE: _____ **DATE**:_____

IN ORDER FOR AIOF TO COMPLY WITH STATE AND FEDERAL GUIDELINES, EACH OF THE ITEMS LISTED ON THIS APPLICATION NEEDS TO BE COMPLETED AND REQUIRES PROOF OF DOCUMENTATION. YOUR APPLICATION WILL BE DELAYED AND YOUR ACCOUNT(S) WILL PROGRESS THROUGH OUR COLLECTION CYCLE UNTIL ALL DOCUMENTATION IS RECEIVED.