onvida Health

Financial Assistance Application

1. Proof of household income (e.g. most recent pay stubs, SSI, unemployment, tax returns). Self-employed must provide most recent tax return to include Schedule C
2. Proof of residency (e.g. utility bill, mortgage/rent statement, property tax bill)
3. Most recent bank statement(s) showing liquid assets
4. Support Statement on the back of this form must be completed if $0.00 income is reported

Please refer to online policy at Onvidahealth.org for additional information. Search "Financial Assistance"

GENERAL INFORMATION

_____

Patient Name Date of Birth SSN#

_____ _____

Patient's Residential address Street Apt No. City State Zip # in household

_____ _____

Patient's Mailing address Street Apt No. City State Zip # in household

_____

Marital Status Telephone No Home/Work Person responsible for paying bill

Household Members	DOB/Sex	Relationship	Employer/School	US Legal Resident Yes or No	SSN
1.					
2.					
3.					
4.					
5.					
6.					

MONTHLY HOUSEHOLD INCOME

	PERSON 1	PERSON 2	PERSON 3	
NAME:	_____	_____	_____	
Gross income per pay period	$_____	$_____	$_____	
How often are you paid?	_____	_____	_____	
Unemployment day of employment _____	$_____	$_____	$_____	last
Social Security, pensions, retirement	$_____	$_____	$_____	
Other sources of income	$_____	$_____	$_____	
Checking account balances	$_____	$_____	$_____	
Savings account balances	$_____	$_____	$_____	
Stocks, bonds, IRA's	$_____	$_____	$_____	
Pay or receive alimony or child support	$_____	$_____	$_____	

(circle one) Child's name_____

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MONTHLY EXPENSES/BILLS

☐ Rent $ _____	☐ Mortgage $ _____	Vehicles: How Many_____	Value $_____
APS, Water, Gas	$ _____	Health Insurance Premiums	$ _____
Child Care	$ _____	Outstanding medical bills	$ _____
Student Loans	$ _____	Prescriptions/Medications	$ _____

COMMENTS TO HELP US UNDERSTAND YOUR FINANCIAL SITUATION:

SUPPORT STATEMENT

(To be completed by the person providing support to the patient)
(Please note: if you are under 19 and living with both parents, parents' income information is needed)

The parent and/or patient have identified myself as providing financial support. Below is a statement listing the services and support that I provide.

_____
_____
_____
_____

I hereby certify and verify that all of the foregoing information given is true and correct to the best of my knowledge and belief. I understand that my signature does not obligate me to be financially responsible for charges rendered to the person for whom I am providing basic financial support.

Signature of person providing financial support to applicant _____

All information given for this Financial Assistance application is true and accurate to the best of my ability. If any information is determined to be false, I understand that it will disqualify me from Onvida Financial Assistance immediately.

_____ _____
Parent/Responsible party signature Date completed

_____ _____
Hospital Representative signature Date completed/reviewed

Onvida Use Only:

If non-U.S. citizen provide immigration card number: _____
Have you been released from prison or jail in the last 4 months? _____
Are you Pregnant? _____ Due Date_____ Single pregnancy? _____
Does anyone in the household have a chronic illness or disability? _____ How long? _____
Do you own, lease or maintain a home outside of Arizona? _____ Do you live temporarily in AZ? _____
What state do you file or claim for your taxes? _____ Filing status: _____ Will you file next year: _____
How many dependents will you claim? _____ Can you be claimed as a dependent? _____

If you have questions, please contact:

Patient Financial Services at **(928) 336-7030** or **1-800-726-9264** (outside Yuma area only)
Onvida Support Center **physical address**: 720 S Rio Vista Drive ▪ Yuma, Arizona 85364

Mailing address: 2400 South Avenue A ▪ Yuma, Arizona 85364 8:00 A.M. – 5:00 P.M. – Monday thru Friday

Account # _____ Guarantor No._____ Date(s) of Service_____