



**Carrell Clinic Foundation  
Financial Assistance  
Application**

Patient Name (Last, First, MI) _____		Social Security Number _____	
Patient Address _____	City _____	State _____	Zip Code _____
Birth Date (Month/Date/Year) _____		Telephone Number _____	
Email _____		Spouse's Name _____	
Employed <input type="radio"/> Yes <input type="radio"/> No		Employed <input type="radio"/> Yes <input type="radio"/> No	
Patient's Employer _____		Spouse's Employer _____	
Telephone # _____		Telephone # _____	

**\*\*If unemployed, please include the previous employer's name and telephone number\*\***

<b>A. Income:</b> Please provide the income for each of the following persons in your household.			
Patient <input type="radio"/> Full Time <input type="radio"/> Part Time - Hours/Week = _____ \$ _____ <input type="radio"/> Hr <input type="radio"/> Wk <input type="radio"/> Bi-Wk <input type="radio"/> Month <input type="radio"/> Year \$ _____ Additional Income  Spouse <input type="radio"/> Full Time <input type="radio"/> Part Time - Hours/Week = _____ \$ _____ <input type="radio"/> Hr <input type="radio"/> Wk <input type="radio"/> Bi-Wk <input type="radio"/> Month <input type="radio"/> Year \$ _____ Additional Income  <b>Total Household Income \$ _____</b>	Please complete only if patient is a minor (if not leave blank) Patient's Father <input type="radio"/> Full Time <input type="radio"/> Part Time - Hours/Week = _____ \$ _____ <input type="radio"/> Hr <input type="radio"/> Wk <input type="radio"/> Bi-Wk <input type="radio"/> Month <input type="radio"/> Year \$ _____ Additional Income  Patient's Mother <input type="radio"/> Full Time <input type="radio"/> Part Time - Hours/Week = _____ \$ _____ <input type="radio"/> Hr <input type="radio"/> Wk <input type="radio"/> Bi-Wk <input type="radio"/> Month <input type="radio"/> Year \$ _____ Additional Income  <b>Total Household Income \$ _____</b>		

**B. Income Verification:** Please provide verification (*send only copies, no original documentation*) for all sources of household income (acceptable documentation listed below). Check attached documents:

Paycheck Remittance      Employer Verification      Credit Inquiry (completed by CC Foundation)  
 IRS Form W-2              Tax Return                      Governmental Assistance (food stamps, CDIC, Medicaid, TANF)  
 Bank Statements          Other (describe below)      Social Security, Workers Compensation or Unemployment Compensation Determination Letters

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

\_\_\_\_\_

**C. Family Members:** Please provide the total number of people in the patient's household. (This number should only include the patient, patient's spouse, and the patient's dependents)

**D. Assets and Other Resources:**

Do you have any assets or other resources available to you?  Yes  No     If Yes, current amount available: \$ \_\_\_\_\_  
*(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)*

Do you have medical insurance?  Yes  No     If Yes, please list provider name: \_\_\_\_\_

Do you have a Health Savings Account or Flexible Spending Account?  Yes  No     If Yes, current amount available: \$ \_\_\_\_\_

**I understand Carrell Clinic Foundation may verify the financial information contained in this Financial Assistance Application ("Application") in connection with the Carrell Clinic Foundation's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize the Carrell Clinic Foundation to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance.**

**I further understand that some physicians and providers may not be contracted with the Carrell Clinic Foundation. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.**

Signature of Patient or Responsible Party \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

<b>For Carrell Clinic Foundation's Use Only</b>	
Application information obtained by Carrell Clinic Foundation representative in person or over the phone, no patient signature required.	_____
Electronic Signature of Carrell Clinic Foundation representative	Date
<b>Notes Regarding Income Verification/Number in the Household:</b>	

## **INSTRUCTIONS FOR HARD COPY OF FORM**

### **CARRELL CLINIC FOUNDATION APPLICATION INSTRUCTIONS**

Please fill in all questions asked on the Financial Assistance Application. In addition, we must receive written documentation of your income along with a letter or email stating your medical history/current medical need and exactly for what you are requesting financial assistance.

**Please note that we cannot consider your application until we receive income verification documentation and the details of your need.**

Please send the required documentation either by mail, email or fax to:

Carrell Clinic Foundation  
Attn: Dana Martinez  
9301 N. Central Expressway  
Suite 400  
Dallas, TX 75231

Email: [dana@carrellclinicfoundation.org](mailto:dana@carrellclinicfoundation.org)

Fax: 214.953.1210

## **INSTRUCTIONS FOR FILLABLE FORM**

### **CARRELL CLINIC FOUNDATION APPLICATION INSTRUCTIONS**

The application is a fillable form. Please fill in all questions asked and click on the "Submit" button. In addition, we must receive written documentation of your income along with a letter stating your medical history/current medical need and exactly for what you are requesting financial assistance. If you prefer to print the application and fill it in by hand, you can submit it at the same time you submit all required documentation. **Please note that we cannot consider your application until we receive income verification documentation and the details of your need.**

Please send the required documentation either by mail, email or fax to:

Carrell Clinic Foundation  
Attn: Dana Martinez  
9301 N. Central Expressway  
Suite 400  
Dallas, TX 75231

Email: [dana@carrellclinicfoundation.org](mailto:dana@carrellclinicfoundation.org)

Fax: 214.953.1210