PAIN TREATMENT
CENTERS OF AMERICA
Less pain. More life.

FINANCIAL ASSISTANCE APPLICATION

Patient Name: ____ Date of Birth: _______________________________

Dear Patient or Guarantor:

You may qualify for the Financial Assistance Program at Pain Treatment Centers of America!

Please fill out this application and submit it back to Pain Treatment Centers of America ("PTCOA") as soon as possible to see if you qualify for a discount on your healthcare costs.

*** All fields on the application must be completed to be considered for financial assistance. Please submit the following documentation within 14 days.**

- ✓ A COPY OF LAST YEAR'S W2 FORM
- ✓ A COPY OF LAST YEAR'S FEDERAL & STATE INCOME TAX RETURN
- ✓ A COPY OF YOUR LAST 2 PAY STUB(S)
- ✓ A COPY OF YOUR MOST RECENT BANK STATEMENT(S) (ALL ACCOUNTS, INCLUDING CHECKING AND SAVINGS)

If you have any questions about the financial assistance program, please call 501-499-6957 to speak to a PTCOA Financial Counselor.

Sincerely,

PTCOA Financial Counselors

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Please fill out all information completely. If it does not apply, check "No" or write "NA." Attach additional pages if needed.

SCREENING INFORMATION:

Do you need an interpreter? Yes ___ No ___ If Yes, list preferred language: ______________________________

Has the patient applied for Medicaid? Yes ___ No ___ (You may be required to apply before being considered for financial assistance.)

Does the patient currently have health insurance? Yes ___ No ___

Does the patient receive state public services such as SNAP, childcare assistance, or WIC? Yes ___ No ___

Is the patient currently homeless? Yes ___ No ___

Is the patient's medical care need related to a car accident or work injury? Yes ___ No ___

PLEASE NOTE: We cannot guarantee that you will qualify for financial assistance, even if you apply. Once you send in your application, we may check all the information you have provided and may ask for additional information or proof of income. Within fourteen (14) calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION:

Patient Name (First, Middle, Last) ____

Employment Status of Person Paying Bill: (Please check all that apply)

- Employed ___ (date of hire): _______________
- Unemployed ___ (how long unemployed): _______________
- Self Employed ___
- Student ___
- Disabled ___
- Retired ___
- Other: ___

FAMILY INFORMATION: Please list all family members in your household, including yourself. Attach additional pages if needed.

Name	Date of Birth	Relationship to Patient	Total Monthly Income

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NOTE: All family members' income must be disclosed. Sources of income include, for example: Wages, Social Security, Unemployment, Self-employment, Worker's compensation, Disability, Child/spousal support, Work study programs (students), Pension, and Retirement account distributions.

MONTHLY EXPENSE INFORMATION:

		Monthly
Electric		$_____________
Water		$_____________
Telephone (landline and/or cell)		$_____________
Gas		$_____________
Food (do not include food stamps)		$_____________
Entertainment		$_____________
Clothing		$_____________
Insurance:	Automobile	$_____________
	Home	$_____________
	Life & Health	$_____________
Installment Payments:	House	$_____________
	Car	$_____________
	Other	$_____________
Other Payments:	Hospital/Doctor	$_____________
	Credit Card(s)	$_____________
	Other	$_____________
TOTAL EXPENSES:		$_____________

Please attach additional pages if there is additional information about your current financial situation that you would like us to know, such as financial hardship, seasonal or temporary income, or personal loss.

I certify that the above information is true and accurate to the best of my knowledge. As part of the application process, Pain Treatment Centers of America may verify information contained in my application and in other documents required in connection with the application, either before the application is approved or as a part of its quality control program. Further, I will apply for any assistance (Medicaid, Medicare, insurance, etc.) which may be available for payment of my medical charges, and I will take the necessary actions to obtain such assistance and will assign or pay to Pain Treatment Centers of America the amount recovered for medical charges. If any information I have given proves to be untrue, I understand that Pain Treatment Centers of America may reevaluate my financial status and take whatever action becomes appropriate.

____ ____________________

Applicant's Signature Date of Request

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To be completed by the Financial Counselor:

___________ Approved

___________ Denied

Comments:

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____

Financial Counselor Name: ______________________________________ Date: ________________

Financial Counselor Signature: ____