

LifeNet, Inc
6300 Hampton Rd
Texarkana TX 75503
903-832-8531
800-832-6395
903-832-0287 (Fax)

Financial Assistance Application

For cases in which a patient is unable to make monthly payments or pay their LifeNet bill because of a fixed income or a financial hardship a Charitable write off or reduced charges are available if the following conditions are met. You must provide verification of your income.

W2 forms... Income tax return... Social Security forms... Food stamps

To be eligible to receive uncompensated or reduced charges, your household income must at or below the following levels to receive the discounts indicated.

Household Size	Annual Household Income				
1	10,400	15,600	20,800	26,000	31,200
2	14,000	21,000	28,000	35,000	42,000
3	17,600	26,400	35,200	44,000	52,800
4	21,200	31,800	42,400	53,000	63,600
5	24,800	37,200	49,600	62,000	74,400
6	28,400	42,600	56,800	71,000	85,200
 Charitable Write off Or Discount	100%	80%	60%	40%	20%

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Application for Conditional Determination or Eligibility

Patient Name _____ **Date** _____

Address _____

Phone Number _____ **Cell Phone** _____

Email Address _____

Social Security Number _____

Guarantor (if different from patient) _____

Employer _____

Number of dependents _____ **Relationship to patient** _____

How much is your yearly income? (Before taxes and deductions) \$ _____

How much other income do you get each year? (Before taxes) \$ _____

How much income do other household members receive yearly? \$ _____

How many people are in your household? _____

If the patient and the applicant are not the same person, complete the following:

Name _____ **Social Security #** _____

If the Conditional Determination of Eligibility is approved, you may be eligible for uncompensated services or reduced charges upon completion of this application. LifeNet Inc requires that you provide written or other satisfactory documentation of information entered. False, incomplete, misleading, or inadequate documentation will not be approved.

Patients who qualify for Uncompensated LifeNet Services receive a discount of 100% of charges. Patients who qualify for Reduced Charges will receive a percentage discount based on their verified financial information and are responsible for any remaining balances.

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Charity Check List

Patient Name _____ Run # _____

Income Information	Yes	No	If yes, amount	Monthly/Yearly
Child Support	<input type="radio"/>	<input type="radio"/>	_____	_____
Wages	<input type="radio"/>	<input type="radio"/>	_____	_____
Food Stamps	<input type="radio"/>	<input type="radio"/>	_____	_____
SSI/ Social Security	<input type="radio"/>	<input type="radio"/>	_____	_____
Work Comp	<input type="radio"/>	<input type="radio"/>	_____	_____
Unemployment	<input type="radio"/>	<input type="radio"/>	_____	_____
Other Income	<input type="radio"/>	<input type="radio"/>	_____	_____
Number of members in household			_____	

Name	Employed		Relationship	Age
	Yes	No		
_____	<input type="radio"/>	<input type="radio"/>	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____

Please provide documentation for all above listed income.

Patient Signature _____ Date _____

Approved by LifeNet Inc _____ Date _____