LIFENET
6225 St. Michael Dr., Texarkana, Texas 75503 (903) 832-8531/Fax (903) 832-0215

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.

PATIENT INFORMATON: RUN #: _____

PATIENT NAME: _____ DOB: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

BEST CONTACT PHONE #: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: □ MARRIED □ SINGLE □SEPARATED □DIVORCED □WIDOWED

SPOUSE NAME: _____ SPOUSE DOB: _____

ADDRESS, IF DIFFERENT: _____

CONTACT PHONE #: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ EMPLOYER PHONE #: _____

EMPLOYMENT: □ EMPLOYED □SELF-EMPLOYED □UNEMPLOYED □RETIRED

EMPLOYER: _____ EMPLOYER PHONE #: _____

IF EMPLOYED: □FULL TIME □PART TIME # OF HOURS/WEEK: _____

$ _____ □HR □WK □BI-WK ADDITIONAL INCOME: $_____

SPOUSE: □FULL TIME □PART TIME # OF HOURS/WEEK: _____

$ _____ □HR □WK □BI-WK ADDITIONAL INCOME: $_____

CHILDREN UNDER 18 YEARS OLD AND OTHER DEPENDENTS WITHIN THE HOUSEHOLD

FULL NAME	DATE BIRTH	RELATIONSHIP OF DEPENDENT

OTHER INCOME:

FOOD STAMPS: MONTHLY AMOUNT- $_____

SSI/SOCIAL SECURITY: MONTHLY AMOUNT- $_____

CHILD SUPPORT: MONTHLY AMOUNT- $_____

WORK COMP: MONTHLY AMOUNT- $_____

UNEMPLOYMENT: MONTHLY AMOUNT- $_____

OTHER INCOME: MONTHLY AMOUNT- $_____

HOUSEHOLD EXPENSES (MONTHLY):

MORTGAGE OR RENT: $_____

UTILITES (ELECTRIC/ WATER): $ _____

VEHICLE(S): $ _____

INSURANCE: $ _____

TV/CABLE/PHONE: $_____

TOTAL AMOUNT: $_____

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All questions must be answered. If a question does not pertain, write N/A on the line.

Proof of income must be included for processing. This may include but not limited to:

- **Last 3 paystubs**
- **Unemployment benefit confirmation slip**
- **Social Security check or award letter**
- **Bank deposit (Print out from bank)**
- **W2 or Income tax return**
- **SNAP letter**

****If you report a $0 income, attach a brief explanation of how you or the patient are meeting basic needs.**

I certify that I am unable to pay for all the costs of necessary services and that the information I have given LifeNet is true and accurate. I understand that LifeNet will use this information to determine my eligibility for financial assistance. I have disclosed all my income and household size.

Patient/Guarantor Signature _____ Date _____

FOR OFFICE USE ONLY:

% APPROVED: _____ **DATE APPROVAL LETTER MAILED: _____**

APPROVED BY: _____

UPDATED 7/22/2022