Application for Financial Assistance

Application Instructions
Please complete all fields on the application and sign where indicated. Please provide all types of **gross family** income as indicated below. Proof of your income should also be provided in the form of income tax return, pay stubs, etc.

If you have questions, please contact InfuSystem at (833) 570-4737 by phone or email at patientservices@infusystem.com.

All information provided is confidential and used only for the purpose of determining financial assistance.

Todays Date: ____/____/____ **Account No.: _____**

Patient Information

Patient Name:		Patient Date of Birth: ____/____/____
Patient Address:		
City:	State:	Zip:
Patient/Responsible Party Phone Number:		
Email Address *(*If you would like to receive communication regarding this application via email)*:		
Number of dependents, **including yourself** living in your household:		

Income Information

Provide the following information for you, significant other and dependents living in the home.

Income Source	**Please provide your current monthly income information below.**
Wages/Self Employment	$
Social Security	$
Pension, Dividends, Interest, Rental Income	$
Unemployment, Workman's Compensation	$
Child Support	$
Other	$
*If you report no income, please provide how you are meeting your daily needs.	

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to determine my ability to pay for services provided by InfuSystem.

Signature:_____ **Date:**_____/_____/_____