Financial Assistance Application

APPLICANT INFORMATION

Name ____ Date of Birth (DOB)_________________________
Last First Middle

Address ____
Street City State Zip

Home Telephone __________________________________ Cell Phone __________________________________

Email __________________________________ Employer____

ALL PERSONS LIVING IN THIS HOUSEHOLD

Parent/Guardian/Adult ____ DOB ________________________

Parent/Guardian/Adult ____ DOB ________________________

1st Child ____ DOB ________________________
2nd Child ____ DOB ________________________
3rd Child ____ DOB ________________________
4th Child ____ DOB ________________________

I AM APPLYING FOR (Check the category for which you are applying)

☐ Collaborative Intake Assessment ☐ Counseling ☐ DPC Membership ☐ HBOT

TO QUALIFY, YOU MUST PROVIDE THE FOLLOWING DOCUMENTS:

I FILED FEDERAL TAXES FOR LAST YEAR

☐ 1040 Federal Tax Form(s) for all incomes in household
☐ Two most recent pay stubs
☐ Photo identification verification required at the time of application

I DID NOT FILE FEDERAL TAXES FOR LAST YEAR

☐ Social Security/Disability Benefit Statement or two most recent pay stubs
☐ Photo identification required at the time of application

MY HOUSEHOLD INCOME HAS CHANGED SINCE I FILED TAXES FOR LAST YEAR

☐ Include current federal tax forms (W-2)
☐ Include explanation for reason of income change

$____ x 12 = ________________________
Monthly Income (Include child support & government assistance) Total Annual Household Income

SOURCES OF MONTHLY HOUSEHOLD INCOME

Monthly Income: $ ________________________ Other Income: $________________________ Total:$______________

Name of Employer (Applicant) ________________________ Name of Employer (2nd Adult)__________________________

I hereby certify that the information in this application is true, accurate and complete to the best of my knowledge. I am aware that it is my responsibility to notify Faithfully Guided Health Center in writing of any change in the information supplied on this application, so that my subsidy can be re-evaluated, thus providing more opportunities for others in need.
Financial assistance applications are confidential. I understand this award, if granted will be for programs and services at Faithfully Guided Health Center. FGHC has the right to request qualifying documents from the recipient as needed for financial assistance renewals as the center deems appropriate.

SIGNATURE OF PERSON COMPLETING THIS FORM

____ DATE________________________________

IN THE SPACE PROVIDED BELOW, PLEASE EXPLAIN HOW FAITHFULLY GUIDED HEALTH CENTER HAS IMPACTED YOU AND WHY YOU WOULD LIKE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE THROUGH THE SCHOLARSHIP PROGRAM.

Faithfully Guided Health Center will guide you to optimum health by connecting spirit, mind and body. We work together as a team of healthcare clinicians and counselors engaged in shared decision-making to help you realize your health goals and live a more abundant life.

Determining your level of support is handled by Faithfully Guided Health Center in a fair and consistent manner. In an effort to be the best stewards of the generous donations provided by our community, Faithfully Guided Health Center requests support documentation to review and verify financial need. Assistance shall be provided to qualifying individuals subject to available resources.

We look forward to partnering with you on your wellness journey.

PLEASE NOTE:

Financial assistance can reduce membership fees up to a maximum of 30%; it does not eliminate them. Financial assistance recipients are subject to all fee increases as are all other members.

Assistance is granted on the basis of financial need. We consider household income and number of legal dependents as the primary criteria. You will be notified within two weeks if you have been awarded assistance. We must have at least 48 hours to process your application, we cannot approve the financial assistance on the same day as your appointment.

As the level of giving and the level of need fluctuate, Faithfully Guided Health Center will periodically re-assess financial assistance awards and policies. Should any changes be required, you will be notified by FGHC.

Faithfully Guided Health Center reserves the right to request updated financial information at any time to comply with guidelines and policy as well as to re-substantiate the level of support.

It is required of the recipient to notify FGHC of changes to their financial status and need for assistance.