Application for Financial Assistance

Client Name: ____ Date of Birth: ___/____/_____
Responsible Party: ____ Relationship: ___________________
Address: ____
Phone #s: Home: ______________________ Work: _____________________ Cell: ____________________
Social Worker/ Care Attendant: ___________________________________ Phone: ____________________

The Emerge Center is a non-profit agency serving all people regardless of race, creed, ethnic origin, or level of income. The costs of services provided are based, to the greatest extent possible, on a person's ability to pay. To qualify for assistance, please fill in the information below. All information will be kept confidential.

The number of people living in your household _____. Their first names, ages, and relationships to you:

____

Income: (*Total for all members of the household)* **Assets:**

Amount (Monthly/Yearly)	**Type of Income**	**Current Value**	**Description**
	Wages		Checking
	Social Security and SSI		Savings
	Pensions		CDs
	Disability		Money Market
	Alimony		Annuities
	Child Support		Stocks
	Welfare and Public Assistance		Bonds
	Interest		Life Insurance Cash Value
	Dividends		IRA/401(K)
	Capital Gains		Other Assets
	Other Income		
	Total		**Total**

We must have the following documentation to process your application (copies, not originals):
___ Pay stubs (last 2 months)
___ Last year's income tax return (if required to file)
___ 4 most recent bank statements for each account
___ W2 and 1099 forms
___ Proof of income that is not directly deposited (example: copy of social security check)

With my signature I agree that this information is true and correct and that I am responsible for any unpaid balance. If any of this information should prove to be knowingly misrepresented I will repay any fees reduced by this agreement. I understand that my continuing eligibility for reduced fees will be reviewed each year.

Signature: ____ Date: _____________________

ELIGIBILITY DECISION
___ You are eligible to receive individual services at ________% of the full fee cost (minimum charge $______).
___ You are eligible to receive group therapy services at _______% of the full fee cost (minimum charge $______).
___ You are eligible for hearing aids at ________% of the full fee cost.
___ Your income exceeds our guidelines.

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