Financial Assistance Application

Thank you for asking about our Financial Assistance Program. A sliding fee scale is available to patients that meet the eligibility requirements for the financial assistance program.

Listed below are the documents you will need to include with your Financial Assistance application:

- ☐ Your signed application form with all information filled in completely
- ☐ Include proof of income for all income sources you have listed on the application in Section 3. Only one document is required to verify each income source. Use the chart in section 3 to verify each income source.

Please Be Aware:

- Missing documents or incomplete information will result in a delay in the processing of your application
- Please submit copies of all supporting documents, keep the original copies for your records
- We will send you a letter by mail or email and by the patient portal letting you know the outcome of your application.
- Applicants must report any changes in their household composition (e.g., birth, marriage, divorce, or custody changes) within 10 business days of their next appointment.

If you have any questions, please reach out to the billing department by phone or email. The application may be submitted in person during normal business hours, through the patient portal, by mail, by fax, or by email to billing@newlife-counseling.com. **The application must be submitted before the scheduled appointment or within 5 business days of an appointment for it to be considered eligible for financial assistance.**

New Life Counseling
227 NW School St.
Ankeny, IA 50023

Billing Phone: 515-661-4129
billing@newlife-counseling.com
Fax: 515-964-3856

Your application may not be accepted if there is incomplete or missing information

Section 1: Patient and Guarantor Information

Patient Name: ______________________________________ Date of Birth: ____/____/______ Marital Status____________________

Guarantor Name (if patient is a minor) _________________________________ Contact Phone Number ______________________

Address ____ City:__________________ State:_________ Zip Code:_________________

Please list all individuals living in your home who contribute to or rely upon household income, excluding boarders or other unrelated individuals. Continue in section 4 if you need more space or would like to provide additional details

Full Name(s) of household members, including additional dependents and legally responsible adults	Date of Birth	Relationship to Patient

Section 2: Employer and Insurance Information

Name of your Employer(s): ____

If unemployed, list last date of employment: __________________________________

Name(s) of your insurance company: ____

Section 3: Income Information

Do you currently receive or qualify for any of the following? *(please provide proof if applicable)*

☐ Food Stamps ☐ WIC ☐ Free/Reduced Lunch Program ☐ Homeless Shelter Use ☐ N/A

☐ Other state assistance program where income verification is required: ____________________________

Please fill out the below chart and provide the corresponding proof of income

Income Source Each Month	Gross Monthly Income Amount for Guarantor	Gross Monthly Income Amount for Spouse or Second Parent	**Please include the most recent copy as proof of income:**
☐ Wages (salary, tips, bonuses, commissions, and income from employment)	$	$	**Most recent pay stub**
☐ Self Employed	$	$	**Tax Return with schedules**
☐ Social Security	$	$	**Social Security award letter**
☐ Pension/Disability ☐ Rental Income	$	$	**Pension/Disability letter** **Tax Return with schedules**
☐ Unemployment ☐ Workers' Compensation	$	$	**Unemployment letter** **Worker's Compensation letter**
☐ VA Benefits ☐ Child Support ☐ Alimony	$	$	**VA Benefits letter** **Award letter, court order or legal agreement**

Required: If you cannot provide the requested documents, please tell us why:

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Your application may not be accepted if there is incomplete or missing information

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Section 4: **Please use this space to provide any additional details that may assist in processing your application or to include overflow information.**

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I would like to be notified by: ☐Mail ☐Email:___________________________________ ☐Both

By signing this form, I hereby declare and affirm that the information provided by me in this document is true, accurate, and complete to the best of my knowledge and belief. I understand that it is against the law to falsify information and doing so may render me ineligible for the financial assistance program.

New Life Counseling reserves the right to modify or terminate the Financial Assistance Program at its discretion. Applicants are responsible for the accuracy and completeness of the information they provide. Submitting this application does not guarantee approval for financial assistance nor does it create any contractual relationship.

New Life Counseling is committed to safeguarding your personal and health information in accordance with our HIPAA Notice of Privacy Practices. The information provided will remain confidential and will be used solely for the purpose of assessing eligibility for the Financial Assistance Program.

Patient/Guarantor Signature ____ Date ____________________

For Office Use Only:

Date Application Received: ____________________________

Received By: ____

Submission Method: ___________________________________

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