GUARDIAN PRIMARY CARE

EMPOWERED IN CARE, EXCELLENCE IN HEALTH

Financial Assistance Application

Ways to Submit Form;

- Print & mail to 1420 Kurre Ln, Cape Girardeau, MO 63701
- Print & bring to 1420 Kurre Ln, Cape Girardeau, MO 63701
- Email completed application to myprovider@guardianprimary.com

Date of Application: _____

Patient Information

- **Patient Name: _____**
- **Date of Birth: _____**
- **Phone Number: _____**
- **Email Address: _____**
- **Home Address: _____**

Household Information

- **Number of people in household (including applicant): _____**
- **Total household monthly income:** $_____
- **Sources of income (check all that apply):**

☐ Employment

☐ Social Security

☐ Disability

☐ Unemployment

☐ Child Support/Alimony

☐ Other: _____

Required Documentation

(Applications without the required documentation will be automatically denied.)

1. **Most Recent Federal Tax Return (Required – Attach Copy)**

   ☐ Attached (MANDATORY)

2. **Additional Income Verification (If Applicable – Attach Supporting Documentation)**

   ☐ Last two pay stubs

   ☐ Unemployment or disability benefits statement

   ☐ Social Security benefits statement

3. **Government Assistance Programs (If Applicable – Attach Proof of Enrollment)**

   ☐ Medicaid

   ☐ Supplemental Nutrition Assistance Program (SNAP)

   ☐ Women, Infants, and Children (WIC)

   ☐ Housing Assistance

   ☐ Other: _____

4. **Hardship Explanation**

   - Briefly describe your financial hardship and why you are unable to pay your medical bills:

_____

_____

_____

Requested Assistance

☐ Full Financial Hardship Adjustment (Balance Reduction)

☐ Discounted Payment Plan

☐ Extended Payment Plan

Patient Certification & Agreement

I certify that the above information is true and correct to the best of my knowledge. I understand that Guardian Primary Care requires my most recent **federal tax return** to determine eligibility. I agree to provide any additional documentation if requested.

I authorize Guardian Primary Care to perform a soft credit pull on my behalf. I understand that this will be utilized in the decision-making process of eligibility determination for financial assistance.

I acknowledge that providing false or misleading information may result in the denial of financial assistance. I also understand that if approved, this assistance applies only to current balances and does not guarantee future reductions. I understand that Guardian Primary Care reserves the right to request further documentation, as applicable, to clarify financial information.

Upon confirmation of receipt of this application, a final determination of approval will be made within 30 business days. Pending approval, no balance is due on behalf of the patient until this determination is made.

Full policy available upon request in Section 35, Article 2 of GPC Practice Almanac.

Social Security Number: _____-____-_____

Signature of Applicant: _____ Date: _____

For Office Use Only

- **Date Received: _____**
- **Reviewed By: _____**
- **Application Status:** ☐ Approved ☐ Partially Approved ☐ Denied
- **Reason for Decision (if denied or partial approval):**
  _____
- **Approval Expiration Date (if applicable): _____**
- **Authorized By: _____ Date: _____**