Financial Assistance Program Application

Relationship to Client:	Application Complet	ed By:				
Alt .phone #: ()	Relationship to Clien	t:				
Please list all household members, including minor children under 21, who live with you and are dependents on your taxes. We need income information for all members of the household who are 21 or older, unless you claim them as a tax dependent. Please include other income, such as SSI/Social Security. For each line of income, please provide supporting documentation. This may include your most recent paystubs or SSI statement that confirm a month's worth of income prior to the date of the application. If documentation is not available to you, we will accept the previous year's tax return instead. (Use an extra sheet if necessary.) First and Last name	Client Name:			Date of Birth:		
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The FAP helps people who are unable to pay all of their medical bills. You may qualify for discounts on medical care through the FAP if: • You do not have health insurance • Your health insurance does not cover all of the medical care you need • You are not eligible for Medicaid or some other type of insurance • You meet the financial criteria I understand that this application for financial assistance and the supporting documentation I provide to F&CS will be used to determine my eligibility for financial assistance. This information is correct and accurate to the best of my knowledge at this time. I agree to notify F&CS of any significant changes to this information that I become aware of during my application process. If any information that has been given proves to be untrue; I understand that F&CS may re-evaluate my financial assistance options.				•	• •	1 IS HOL available
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Signature of applicant: Date:	to determine my elig at this time. I agree application process.	gibility for for to notify If any infor	financial assistand F&CS of any sigr rmation that has l	ce. This information is conditional is conditional infinite that is in the condition in the	rrect and accurate to the best on formation that I become awa	of my knowledge re of during my
	Signature of applicar	nt:			Date:	

RETURN TO:

Family & Children's Service of Ithaca Attn: Billing Department. FAP 127 West State Street Ithaca, NY 14850

Ph: 607-273-7494