AURORA INTEGRATED ONCOLOGY FOUNDATION

APPLICATION FOR CHARITY CARE

Please MAIL or FAX the Completed Form AND Supporting Documentation To:
Radiation Business Solutions
1044 Jackson Felts Rd, Joelton, TN 37080
Fax: 907-802-6136

For questions call: (907) – 302 – 4845
Or email:
Financialassistance@radiationbusiness.com

Patient Information

Patient Name:	Radiation Center:
Address:	Birthdate:
City, State, Zip:	
Email:	Phone:
Marital Status: ☐SINGLE ☐MARRIED/PARTNERED ☐DIVORCED ☐SEPARATED ☐WIDOWED	

Financial Information

GUARANTOR, SELF, SPOUSE AND DEPENDENTS CLAIMED ON TAXES	DATE OF BIRTH	RELATION TO PATIENT	MONTHLY NET INCOME	SOURCE OF INCOME

TOTAL MONTHLY NET INCOME: $ _____

IF NO MONTHLY WAGES ARE LISTED ABOVE, PLEASE EXPLAIN HOW YOU TAKE CARE OF YOUR LIVING EXPENSES:

IF UNEMPLOYED, PROVIDE THE DATE EMPLOYMENT ENDED: _____
HAVE YOU APPLIED FOR UNEMPLOYMENT OR COBRA? ☐ YES ☐ NO

ARE YOU CURRENTLY INSURED? ☐ YES ☐ NO
IF UNINSURED, HAVE YOU APPLIED FOR MEDICAID/DISABILITY? ☐ YES ☐ NO
IF YES, WHAT IS THE CURRENT STATUS: _____

DO YOU RENT OR OWN YOUR PRIMARY RESIDENCE? ☐ YES ☐ NO
MONTHLY PAYMENT (RENT OR MORTGAGE): $_____

PLEASE LIST ANY OTHER MONTHLY EXPENSES (Utilities, Loans, Credit Cards, Premiums, etc.)

1. _____ Amount: $ _____
2. _____ Amount: $ _____
3. _____ Amount: $ _____
4. _____ Amount: $ _____

LIST ALL ASSETS, VEHICLES (MAKE/MODEL/YEAR), PROPERTIES (NOT PRIMARY RESIDENCE), ETC.

1. _____ Value: $ _____
2. _____ Value: $ _____
3. _____ Value: $ _____
4. _____ Value: $ _____
5. _____ Value: $ _____

CHECKING ACCOUNT: ☐ YES ☐ NO	BANK NAME:	ACCOUNT BALANCE: $
SAVINGS ACCOUNT? ☐ YES ☐ NO	BANK NAME:	ACCOUNT BALANCE: $
STOCKS, BONDS, IRA's, 401K, CD: ☐ YES ☐ NO	BANK NAME/LOCATION:	ACCOUNT BALANCE: $

PROVIDE ANY OTHER INFORMATION SUPPORTING YOUR FINANCIAL POSITION, OR DESCRIBE ANY FINANCIAL HARDSHIPS:

PLEASE SUBMIT **COPIES** OF THE FOLLOWING DOCUMENTS IN SUPPORT OF THE INFORMATION PROVIDED ABOVE:

- **PAYCHECK STUBS** OR YOUR MOST RECENT FEDERAL INCOME TAX RETURN
- **LETTER OR BANK STATEMENT** VERIFYING SOCIAL SECURITY OR OTHER GOVERNMENT BENEFITS RECEIVED
- **BANK STATEMENTS** FOR CHECKING, SAVINGS, OR INVESTMENT ACCOUNTS
- **TAX STATEMENTS** SHOWING VALUE OF REAL ESTATE AND PERSONAL PROPERTY (EXCLUDING PRIMARY RESIDENCE)

I CERTIFY THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE, ACCURATE AND TRUE. I UNDERSTAND THAT FRAUDULENT OR MISLEADING INFORMATION WILL MAKE ME INELIGIBLE FOR FINANCIAL ASSISTANCE. I AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED BY AURORA TO VERIFY THE INFORMATION PROVIDED. SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, I AUTHORIZE AURORA TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBLITY FOR THAT FUNDING.

APPLICANT SIGNATURE: _____ **DATE**:_____

IN ORDER FOR AIOF TO COMPLY WITH STATE AND FEDERAL GUIDELINES, EACH OF THE ITEMS LISTED ON THIS APPLICATION NEEDS TO BE COMPLETED AND REQUIRES PROOF OF DOCUMENTATION. YOUR APPLICATION WILL BE DELAYED AND YOUR ACCOUNT(S) WILL PROGRESS THROUGH OUR COLLECTION CYCLE UNTIL ALL DOCUMENTATION IS RECEIVED.