HULST JEPSEN
PHYSICAL THERAPY

Application for Financial Assistance

GENERAL INFORMATION			
Patient Name		*Date of Birth*	
Responsible Party Name (if patient is a minor)		*Date of Birth*	
Address	*City*	*State*	*Zip*
Email	*Cell Phone #*	*Other Phone #*	
Social Security Number	*Number of People in Household*		

EARNED INCOME Please complete this section about income (before taxes and deductions) for each family member who works		
Name of Working Family Member	*Amount Earned*	*How Often*
Employer Name & Address		

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Employer Name & Address		

Name of Working Family Member	*Amount Earned*	*How Often*
Employer Name & Address		

**Income verification must be provided for ALL adults in your household.*

OTHER INCOME Please complete this section for each family member who receives other forms of income not from an employer (before taxes and deductions)				
TYPE OF INCOME	**AMOUNT**	**FREQUENCY**		
		WEEKLY	**MONTHLY**	**ANNUALLY**
Social Security	$			
Railroad Retirement	$			
Veteran's Benefits	$			
Retirement Funds	$			
Annuities	$			
Pensions	$			
Child Support	$			
Alimony	$			
Unemployment	$			
Workers' Comp	$			
Rental Income	$			
Trust Income	$			
Transitional Assistance	$			
Dividend Income	$			
Bank Account Income	$			
Other:	$			

**Income verification must be provided for ALL adults in your household.*

Do you anticipate your income changing over the next 3 months? ☐ YES ☐ NO

If yes, please provide a reason:

Do you have a health savings account? ☐ YES ☐ NO

If yes, please provide the current balance of the account: $_____

FAMILY EXPENSES Please complete this section about all family expenses				
TYPE OF EXPENSE	**AMOUNT**	**FREQUENCY**		
		WEEKLY	**MONTHLY**	**ANNUALLY**
Mortgage / Rent	$			
Vehicle Payments	$			
Child Care	$			
Loan Payments	$			
Auto Insurance	$			
Health Insurance	$			
Other Insurance	$			
Gas	$			
Water	$			
Electric	$			
Cable/Internet	$			
Food/Groceries	$			
Phone(s)	$			
Alimony	$			
Child Support	$			
Outstanding Medical Bills	$			
Prescriptions	$			
Credit Card #1	$			
Credit Card #2	$			
Credit Card #3	$			
Credit Card #4	$			
Other:	$			

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By signing below, I agree to the following:

I certify that all the information provided in this application is true and to the best of my knowledge.

I understand that if I am determined to be eligible for a percentage discount and I do not fulfill my agreement to pay monthly towards the remaining balance that was not determined to be eligible, that this discount will be void and I will be responsible to pay the balance in full.

I understand that if I am determined to be eligible for financial assistance, I agree to tell Hulst Jepsen Physical Therapy of any changes in my family status including family size, income changes, and health insurance which could change my eligibility for financial assistance.

I understand that this assistance is for this episode of treatment only and if I should come back to Hulst Jepsen Physical Therapy at another time I will need to reapply for assistance.

I understand that the information provided in this application will be kept confidential and not shared with any outside entity or person(s).

_____ _____

Signature of Applicant Date

_____ _____

Signature of Responsible Party (if minor) Date

SUBMITTING YOUR APPLICATION

Along with this application you must provide a copy of your current tax filing and income verification for ALL adults in your household. Acceptable forms of income verification include:

- ☐ Previous years taxes
- ☐ A month's worth of paystubs
- ☐ Social security letter stating what their monthly benefits will be for the year
- ☐ Bank statements
- ☐ Proof of deposits going into their bank with the institution clearly noted

Once completed, please email all paperwork to billingteam@hjphysicaltherapy.com
A member of our Billing department will reach out to you with determination information.
If you have any questions, please call us at (616) 608-9979.

********** **BILLING USE ONLY** **********

Total Income per Year	
Total Income per Month	
Total Expenses per Month	
Total Discretionary Income per Month	
Bracket of Discount based on Federal Poverty Level	
% Eligible for Waiver	

_____ _____

Billing Staff Member Date of Determination