REQUEST FOR FINANCIAL ASSISTANCE

I, _____, request financial assistance in paying for the costs of medical treatments provided by Rocking Horse Center staff. Please list **ALL** household member(s) below (use back of paper if necessary).

	Name	Birth date		Name	Birth date
1			4		
2			5		
3			6		

I understand that it is Rocking Horse Center's policy to treat patient for needed medical services regardless of the patient's ability to pay the full costs of that care. Rocking Horse Center shall determine in its sole discretion what portion of its regular charge will be discounted based on the information provided on this application. ***I have already*** fully informed Rocking Horse Center of any and all health insurance benefits available to household members and ***understand*** that no discount will be applied until a claim response has been received from any and all applicable insurance.

I agree to fully inform Rocking Horse Center of the source and amount of **ALL** household income available to me and my family including, but not limited to, employment, unemployment, disability, and child support.

I agree to make prompt application for any public or private medical service program that I and/or may family may be eligible for based on my household size and income as identified herein by Rocking Horse Center.

I also understand that, if I qualify for financial assistance from Rocking Horse Center, any reduction in the portion of the full fee that I must pay is dependent upon my carrying out the following responsibilities:

- ***I agree*** to carry out the treatment recommendations fully and completely and agree to notify Rocking Horse Center of any situation which prevents me from fully complying with the treatment plan.
- ***I agree*** to pay the portion of the full charge which is determined to be my direct responsibility at the time of service or make payment arrangements to assure prompt and full payment. It is **MY** responsibility to inform Rocking Horse Center of any circumstances which prevents me from meeting this obligation **and my** responsibility to make any new arrangements necessary to meet this financial obligation.
- ***I understand and agree*** that my failure to fulfill the above responsibilities may result in removal of all financial adjustments made as a result of this application. In this event, I understand that I will be financially responsible for the full charges for all care rendered under this understanding.

Further, I understand that any falsification of information provided herein will terminate my right and that of my family to any financial assistance.

The following household members have income earned from work or other sources: (Show **gross income** before deductions from child support, disability, work, unemployment, social security, etc.)

Household Member Name	Employer/Other Source	Gross Income
		$ per
		$ per
		$ per

I have read, understood and accept the above conditions to this application for financial assistance, I authorize Rocking Horse Center to verify income from any source including employers, governmental agencies, and other household members and/or references.

SIGNED: _____ **Date:** _____

Expiration Date:

PLEASE NOTE: This information must be updated every twelve (12) months or immediately in the event of income changes!

Office Use Only:	YInc:	FMSize:	Scale %:	VCopay: