THE UNIVERSITY OF
ALABAMA AT BIRMINGHAM
CIVITAN–SPARKS CLINICS

PATIENT/FAMILY FINANCIAL ASSISTANCE APPLICATION ENCLOSED

This letter was sent to you because you asked Civitan/Sparks Clinics for a financial aid application. To find out if you can get help with your bill, we must have all applicable items listed below. If we do not receive these forms before your next visit to the Civitan/ Sparks Clinics, you will be responsible for paying on the day of your visit.

Once you have finished the form and have all of the items listed below, please mail them in the return envelope provided.

If you need help with this or have any questions, please call our office at 205-934-1068 or 205- 975-8764. **If these are not received, your application for help with your bill will be denied.**

1. Complete and sign; Application.
2. Proof of your earnings and your spouse's earnings if applicable.
   The following information, as it pertains to your situation, must be received:
   - A copy of your W-2(s) and two (2) or more of your most recent pay stubs (and a letter from your boss that is on company letterhead proving gross income.)
   - Proof of alimony, child support, unemployment, pension, etc.
   - Proof of Social Security income, if applicable.
3. If you are unable to work due to an illness or disability, a letter from your doctor for proof you are unable to work is required.
4. If you get no income and family or friends are helping you, a letter explaining this is required. The letter must be signed by any person(s) supporting you financially.
5. If you or anyone in your home receives food stamps, you must provide a copy of your most recent award letter or verification letter.
6. A copy of your denial letter from Medicaid stating you are not eligible for the Medicaid program.

*Falsifying information on the Financial Assistance application will result in us taking back any financial assistance provided to you up to that point and make you fully responsible for your medical bills.

Community Health Services Bldg 20
930 20th Street South, Suite 101
Phone: 205 .934.5471
Fax: 205.975-2380
www.circ.uab.edu/Sparks/

Mailing Address:
The University of Alabama at Birmingham
Civitan-Sparks Clinics
CH19, Suite 307
1530 3rd AVE SO
BIRMINGHAM AL 35294-2041

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_____ MR#_____
Office Use Only

* Please Print Date: _____

PATIENT INFORMATION

Name _____ D/O/B _____
(Last) (First) (MI) (MM/DD/YY)

Present Address _____
Street/Apt Number City State Zip

Previous Address _____
Street/Apt Number City State Zip

Telephone Number (____) _____ (____) _____
Home Work

Social Security Number _____

RESPONSIBLE PARTY INFORMATION

Name _____ D/O/B _____
(Last) (First) (MI)

Present Address _____
Street/Apt Number City State Zip

Previous Address _____
Street/Apt Number City State Zip

Telephone Number (____) _____ (____) _____
Home Work

Social Security Number _____

Relationship to Patient _____

***List all persons residing in household*:**

	NAME	AGE
Head of Household		
Spouse		
Adult Family Members		
Children or		
Other Dependents		

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INCOME		EXPENSES	
DESCRIPTION	**MONTHLY INCOME**	**DESCRIPTION**	**MONTHLY EXPENSE**
List monthly household income from any of these sources:			
A. GROSS SALARY FOR HEAD OF HOUSEHOLD	$_____	A. RENT/HOUSE PAYMENT	$_____
NET SALARY FOR HEAD OF HOUSEHOLD	$_____	B. FOOD	$_____
EMPLOYER NAME _____	_____	C. UTILITIES	$_____
B. GROSS SALARY FOR SPOUSE	$_____		(Elec./Water/Phone/Gas)
NET SALARY FOR SPOUSE	$_____	D. REPAIRS	$_____
EMPLOYER NAME _____	_____		(Car or Home)
C. DIVIDEND AND INTEREST	$_____	E. INSTALLMENT LOANS - LIST:	
D. RENTAL INCOME	$_____	F. _____	$_____
E. PENSION INCOME	$_____	G. CAR PAYMENT	$_____
F. CHILD SUPPORT (INCOME)	$_____	H. OTHER CHARGE ACCOUNTS	$_____
G. ALIMONY (INCOME)	$_____	I. VISA/MASTER CARD	$_____
H. ADDITIONAL INCOME	$_____	J. CELL PHONE/PAGER	$_____
I. SOCIAL SECURITY BENEFITS	$_____	K. CABLE TV	$_____
J. V.A. BENEFITS	$_____	L. CHILD SUPPORT	$_____
K. WELFARE	$_____	M. ALIMONY	$_____
L. OTHERS - LIST	$_____	N. CHILD CARE	$_____
		O. MEDICAL TRANSPORTATION	$_____
		P. EDUCATION (Student only)	$_____
		Q. MONTHLY MEDICATION(S)	$_____
M. TOTAL INCOME PER MONTH	**$_____**	**R. TOTAL EXPENSES/MONTHLY**	**$_____**

I understand that the information I submit is subject to verification by Civitan/Sparks Clinics and subject to review by state and/or federal enforcement agencies and others as required.

I certify under the statutes of perjury that the information on these pages is true and correct, and that I do not have the financial means to pay for clinical care rendered.

If your financial situation changes in the upcoming calendar year, these changes are to be reported to the Civitan/Sparks Clinics immediately.

****My signature on this application verifies that if I am entitled to any other medical benefits, including, but not limited to, a supplemental insurance policy, that I will provide the Civitan/Sparks Clinics with this information. Should I choose not to give any information regarding my supplemental insurance carrier, my application for assistance may be denied and I may be responsible for the total amount of bills accrued at the Civitan/Sparks Clinics.**

Signature of responsible party_____ Date signed _____

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Detailed Questionnaire

1 - If unemployed: How long? _____ Were you removed from work by a physician or for a medical reason? _____

Comments: _____

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2 - Have you applied for Social Security Disability? _____ Date application submitted? _____

Approved_____ Denied_____ Pending_____

Comments: _____

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3 - Have you applied for Medicaid? _____ Approved_____ Denied_____ Pending_____

Comments: _____

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4 - Have you or your spouse ever served in the military? _____ Have you applied for Veterans benefits?_____

Comments: _____

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5 -Have you or your child suffered an injury related to a motor vehicle accident? _____ Auto Insurance? _____

Are you involved in a lawsuit seeking a monetary settlement relating to the accident?

Comments:_____

_____

Other pertinent comments:_____

_____

_____

_____

_____

I certify under the statutes of perjury that the information on this page is true and correct, and that I do not have the financial means to pay for clinical care rendered.

Falsification of any portion of this application may result in the denial of assistance.

Signature of responsible party _____ Date signed_____

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Financial assistance and discounted care does not cover the following services:

Acquire C Therapy
ADHD Summer Treatment Program
Early Intervention Services
Hearing Aids and Speech Augmentation Equipment
Hearing Aid Batteries
Other Specialized Equipment and Supplies

This is an example of services not covered under the financial assistance or discounted care program. This list may not include all exclusions to the program. Should you have questions regarding your particular plan of care, please feel free to call our office.

We reserve the right to change or update covered or non-covered services without notice.

My signature below verifies that I have read and understand the list and statements above.

Signature_____ Date_____

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