Financial Assistance Program
Noland Health Services, Inc.

Noland Health Services, Inc. (Noland) provides financial assistance to individuals who satisfy certain income requirements. To determine if a person may qualify for financial assistance, we need certain financial information as indicated in this application. Your cooperation will allow us to give you all due consideration to your request.

Please complete the Financial Assistance Application and return along with the requested documentation to:

Noland Health Services, Inc.
Central Business Office Attn: Director of CBO
600 Corporate Parkway, Suite 100
Birmingham, AL 35242

Applications received by us without the requested documentation will not be considered until such time that the documentation is received.

Please feel free to contact us if you should need assistance in completing the application at (205) 783-8443. Our hours are Monday through Friday 8:00 am until 4:30 pm.

Required documents:
Proof of income: Prior year Federal and State income tax return. If you did not file income tax returns, please call the Internal Revenue Service for a verification letter reflecting no federal income tax return was filed. This letter may be obtained by calling 1-800-829-1040 or 1-800-829-0922. If you have no income, please provide a letter stating the circumstances of how needs of daily living are provided.

Proof of expenses: Copy of mortgage payment or rental agreement, copies of credit card statements, bank loans, car loans, insurance payments, utilities, cable and cell phones. Other documents as requested.

Current Banking/Investment statements. Provide the last two monthly statements for all active accounts: checking, savings, and investment accounts.

The information provided in this application is subject to verification by Noland and will be used to determine your ability to pay your debt. Any false information provided by you will result in denial of financial assistance.

Noland Health Services

Financial Assistance Application

Patient/Resident: _____ Applicant Name: _____

Patient/Resident/Applicant address: _____

_____

Patient/Resident/Applicant phone number: _____

Facility: _____ Date of Service: _____

Account #: _____ Amount of request: _____

Number of residents in household (include all adults and dependents): _____

INCOME

Gross salary/wages (patient/resident) _____

Gross salary/wages (other household) _____

Total Household Social Security Income _____

Total Household Retirement/Pension Income _____

Total Household Self Employment Income _____

Total Household Dividend/Interest/Annuity Income _____

Other Income - Define _____

Other Income - Define _____

- Please provide a copy of the previous year income tax return to verify income.
- If employed, please provide a copy of the most recent pay stub.

HOUSEHOLD SUPPORT

Please list all benefits currently received from social and government resources, such as Food Stamps, rent subsidy, Medicaid, utility assistance, daycare, etc. Please note each agency or source of support and the monthly amount of the support received.

Source	Amount

EMPLOYMENT INFORMATION

Please list the name and phone number of the employer for adult members of the household.

Name: _____ Name of Employer: _____

Address: _____ Phone Number: _____

Name: _____ Name of Employer: _____

Address: _____ Phone Number: _____

If there is no current employment, please enter a brief statement of why.

_____

_____

_____

_____

HOUSEHOLD ASSETS

Please list all houses, property, vehicles, boats, etc. and the approximate value. Also, please list all bank accounts, CDs, brokerage accounts with current value, including life insurance policy cash values.

Description	Value / Worth / Balance	Description	Value / Worth / Balance

OUTSTANDING DEBT AND LIABILITIES

Please list all loans and credit accounts owed. Include the creditor name, amounts, and monthly payments. It is very important to list all physician and other medical indebtedness. If necessary, use another sheet of paper and attach it to the application.

Creditor / Company Owed	Balance / Amount Owed	Monthly Payment

LIVING EXPENSES

Please list the approximate household monthly expense for the following.

	Payee	Monthly Payment
Rent / Mortgage		
Food		
Electricity / Gas		
Telephone		
Medication / Drugs		
Television / Internet		
Property Taxes (Annual)		
Insurance Premium		
Insurance Premium		
Insurance Premium		
Other - Define		
Other - Define		
Other - Define		

CONSIDERATIONS

The application form must be completed in full. If the application cannot be completed in full, provide a written explanation as to why. Any other information that is felt to be relevant and important to this application can be noted on a separate piece of paper and attached to this form. Without a complete application or acceptable explanation, the application will be subject to denial.

All financial assistance is provided at the sole discretion of Noland Health Services and can be revoked at any time. A review and final decision will be made within 30 days of the receipt of the completed application and a notice of decision will be mailed to the applicant.

Applicant / Patient / Resident Signature

Date

If signed by applicant, relation to the patient/resident