Therapy Solutions FOUNDATION

TS Foundation Financial Assistance Application

Name: _____

Date: _____

Email: _____

Complete application and email copies of the following:

- Tax returns and supporting schedules (previous 2 years)
- Social Security benefits* (if applicable)
- Pay Stubs* (most recent 3 months)
- Bank Statements* (most 3 recent 3 months for all accounts)
- W-2 or Unemployment Statements

I have applied for or will apply for federal or state medical assistance or have verified my healthcare exchange plan eligibility.

Yes

Reason: _____

I have a lawsuit, settlement, personal injury, or liability claim pending.

No

Reason: _____

I have the availability of insurance through my employer or my spouse's employer.

Yes

Reason: _____

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RESPONSIBLE PARTY

Name (First, Middle, Last): _____

Social Security Number: _____

Birth Date (MM, DD, YYYY): _____

Address: _____

City, State Zipcode: _____

Cell Phone Number: _____

Household Size: (Total) _____

Marital Status: ***Married***

Employment Status: Full Time

Employer Name: _____

Employment Length: _____

Unemployed Date/Length: _____

Dependents:

Full Name	*Relationship*	*Birth Date (mm-dd-yyyy)*

BANKING/FINANCIAL INFORMATION

Bank Name: _____

Account Type: ***Checking***

Bank Name: _____

Account Type: ***Checking***

Bank Name: _____

Account Type: ***Checking***

PROPERTY

Type of property (select all that apply)

- Secondary Residence/Vacation Home
- Land
- Rental Property
- Business/Farm Equipment
- Other/Recreational Vehicle
- None

Complete this section if applicable:

Property Type	*Estimated Value*	*Unpaid Balance*
Secondary Residence/Vacation Home		
Land		
Rental Property		
Business/Farm Equipment		
Other/Recreational Vehicle		

ADDITIONAL SOURCE OF INCOME

Income Description (check all that apply)

- Interest/Dividends
- Pension/ Retirement
- Rental/Property
- Disability
- Alimony/Child Support
- Other

Income Description	*Source*	*Monthly Income Amount*
Interest/Dividends		
Pension/ Retirement		
Rental/Property		
Disability		
Alimony/Child Support		
Other		

INSURANCE

Type of Insurance:

- Health
- Dental
- Vision

Policy Provider: _____

Monthly Payment: _____

MEDICAL DEBT

Type of Medical Debt (check all that apply):

- Medical Doctor
- Dentist
- Medical Hospital
- Medical Clinic
- Other Medical Facility

Type of Medical Debt	*Unpaid Balance*	*Monthly Payment*
Medical Doctor		
Dentist		
Medical Hospital		
Medical Clinic		
Other Medical Facility		

SIGNATURE/DATE

Signature: *** _____

Printed Name: _____

Date: _____