Radiant Health Natural Medical Center

Financial Assistance Application

Applicant Demographics			
First Name:	Last Name:	MI:	
Street Address:		City:	
Date of Birth:			
State:	Zip Code:	Account#	SSN#

Household Information Please fill in the information for all members of your household (self, spouse, children, other dependents)

Name	DOB	Relationship	SSN	Driver's License/ID#	Phone Number

Household Income Please list all sources of income coming into the household		
Income Type	Who receives this income	Gross Monthly Amount
Self-Employment		
Wages, Tips, Commissions		
Other Unearned Income (Please indicate Source)		
Pension Income		
Property Rental Income		
SSDI/RSDI Income		
SSI Income		
Unemployment Income		
VA Benefits		
Workers Compensation		
Total:		

Household Assets Please list all assets owned by any household member		
Asset Type	Who receives this Asset	Gross Monthly Asset
Checking Account		
Savings Account		
Investments, including stocks and bonds		
Trust funds		
Money Market accounts		
Mutual funds		
Other investment funds that will not incur a penalty		
Total:		

I am applying for Financial Assistance for healthcare services rendered at Radiant Health Natural Medical Center. I hereby certify that the above information is true and correct to the best of my knowledge. I also understand that the appropriate documents must be provided and/or mailed with this application for consideration of Financial Assistance.

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Signature of Patient, Spouse, or Legal Representative Date