

## Radiant Health Natural Medical Center Financial Assistance Application

Applicant Demographics:		
First Name:	Last Name:	Date of Birth:
Street Address:		City:
State:	Zipcode:	SSN#

### Personal Statement of Application:

In your own words please share why are you seeking financial assistance:

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Household Information: Please include all members in your household		
Name:	Date of Birth:	Relationship:

Household Income:		
Income Type:	Who Receives This Income:	Gross Monthly Income:
Self-Employment		
Wages, Tips, Commission		
Other Unearned Income		
Pension Income		
Property Rental Income		
SSDI/RSDI Income		
SSI Income		
Unemployment Income		
Workers Compensation		
VA Benefits		
Total:		

Household Assets:		
Asset Type:	Who Receives This Income:	Gross Monthly Income:
Checking Account		
Savings Account		
Investments (Stock, bonds, ect)		
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

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Date