Client ID #_____ Please Return By: _____

APPLICATION FOR FINANCIAL ASSISTANCE

INFORMATION AND INSTRUCTIONS: The sliding fee scale is based on Federal Poverty Guidelines. Client fees will be based on household income and the number of people in the household. Eligibility for assistance will be considered without regard to race, color, gender, age, disability, religion, veteran status, political belief, sexual orientation, marital status, financial status, and/or any other characteristic or trait which sets an individual apart from others and may be construed to be used to provide less than equivalent treatment.

THIS APPLICATION IS REQUIRED IF YOU WISH TO BE CONSIDERED FOR REDUCED FEES. PLEASE NOTE:

- Aspire requires all clients to prove the accuracy of the information reported with supporting documentation. Without adequate documentation, your request may be refused.
- All clients who benefit from reduced fees are required to immediately notify us of any changes in income and/or household size.
- A fee discount update can be requested at any time by a client or a designated Aspire representative.

THE ITEMS YOU WILL NEED TO COMPLETE THE APPLICATION ARE LISTED BELOW.
PLEASE BRING THESE ITEMS WITH YOU TO THE BUSINESS OFFICE SO THAT YOUR APPLICATION CAN BE PROCESSED. ALL DOCUMENTS MUST BE BROUGHT IN PERSON. INCOMPLETE DOCUMENTATION *WILL NOT BE ACCEPTED*. ALL DOCUMENTS MUST BE CURRENT AND ORIGINALS.

APPLICATIONS ARE PROCESSED MONDAYS THROUGH FRIDAYS FROM 7:30AM-12:45PM AND 2PM-3PM IN THE ADULT MEDICATION CLINIC (YELLOW AREA).

Check the appropriate boxes for this client.

☑ **All that apply must bring the following:**

1. **Valid Orange, Osceola, Brevard or Seminole County** ID or a passport with supporting documents showing that an ID has been applied for.
2. **Social Security Card** for the client and all dependents or a letter from the Social Security Office stating the cards have been applied for.
3. Current Utility Bill, Lease or Mortgage Statement (**Must be the same address we have on file**)
4. Medicaid denial letter or proof of applying.
5. All household income including: Alimony, Child Support, Student Loans, or a Trust Fund.

☐ Unemployed applicants or those being supported or maintained by another person:

1. If you are being supported by another person, you must provide a current notarized letter of support (if the supporting persons come with you they need to show a valid photo ID and the letter does not need to be notarized).
2. Food stamp award or denial letter.
3. Documentation of support – i.e. unemployment compensation or denial letter.

☐ Self-employed:
1. Consecutive tax forms for the last 2 years.
2. If missing tax forms a ledger of Business losses and profits from an Accountant for the missing year.

☐ Employed:
1. 1 month of consecutive pay stubs – 2 stubs if paid biweekly or semi-monthly, 1 if monthly, and 4 if weekly.
2. If you are employed at a labor pool bring in all your pay stubs for the past month.
3. If you are on commission bring in at least 3 consecutive months of stubs.

☐ Receiving SSDI or SSI:
1. Copy of the Award letter, check, or if direct deposit a current bank statement.
2. Food stamp award or denial letter.

☐ Homeless:
1. Letter from a shelter (on shelter's letterhead) or case manager.
2. Food stamp award or denial letter.

*****PLEASE NOTIFY US IF YOU HAVE APPLIED FOR OR HAVE INSURANCE*****

I hereby certify that all information I provide to Aspire is true to the best of my knowledge and belief. I understand that in accordance with Florida Statutes Section 817.50 providing false information to defraud a healthcare provider for the purpose of obtaining goods and services is a second-degree misdemeanor. I authorize all banks, employers, and/or financial institutions to disclose financial information concerning me to authorized representatives of Aspire Health Partners, Inc.

_____ _____
Client, Guardian, or Caretaker Signature Date

_____ _____
Aspire Representative Signature Date

OFFICIAL USE ONLY

CRITICAL DATA **AUTHORIZED BY:**

CLIENT NUMBER _____
TOTAL NUMBER OF DEPENDENTS _____ EMPLOYEE NAME _____
TOTAL HOUSEHOLD INCOME _____
ELIGIBLE DISCOUNT _____ DATE _____

NOTES

Medicaid Outcome: ☐ **455 Applied** ☐ **470 Denied** ☐ **Other:**