







Special Consideration Application

Personal Information			
Patient Name:	Run#:	Form Initiated By	:
Application Due by:		ce: \$ E	
Section 1: Applicant			
Relationship to Patient:			
-		SS	SN:DOB
Home Phone #: ()			
			ate: Zip:
Name of Applicant's Employer:			
Employer Phone: ()	Length of	Employment:	
Section 2: Co-applicant (Pare	nt, Spouse, or Partner)		
Relationship to Patient:			
Last Name:	First Name:	SS	SN:DOB
Home Phone #: ()	Cell	Phone # ()	-
Name of Co-applicant's Employ	/er:	Pos	sition:
Employer Phone: ()	Length of Em	iployment:	
Section 3: Please list everyone	e living with patient in h	ome:	
Household Members: Name	Relationship	Age	Employment Status
C1' 4 M-1''1	1	'	
Section 4: Medicaid			
Have you filed for Medicaid?	□ No □ Yes Policy numb	oer:	If Denied, denial date:
Reason for denial:			
Section 5: Incident Information	on		
Was transport due to auto acci	dent? □ No □ Yes If	yes, what is name of auto	insurance?
Claim number:	Adjuster	:	Phone #: ()
Have you received a settlemen	t from any insurance?	No ☐ Yes If yes, how i	much? \$
Do you have an Attorney? Nan	ne:	Phone#: ()_	
Were you a victim of a crime?	□ No □ Yes If yes, did	you apply for Victims of 0	Crime? □ No □ Yes
If yes, claim number: _	Adjuster	:	Phone#: ()
Were you injured at work? $\ \ \Box$	No ☐ Yes If yes, plea	ase provide carrier name	:
If yes, claim number:	Adjuster	:	Phone#: ()
Were you injured at a business	or home (other than your ov	wn)? 🗆 No 🗆 Yes	
If yes, claim number:	Adjuster	·:	Phone#: ()
Section 6: Monthly Expenses			
Rent/Mortgage (Circle one)	\$	Credit Card Payment	\$
Groceries:	\$	Loan Payments	\$
Auto Loan		Other:	\$
Cable / internet	\$	0.1	\$
,		Other:	,
Cell phone / home phone	\$		\$
Utilities (gas, water, electric, trash)	\$	Total Expenses	\$

Section 7: Income	Section 7: Assets				
Applicant's Income:	\$	Real Estate/Rental Property Equity:	\$		
Co-Applicant's Income:	\$	All Checking Accounts Balance's:	\$		
		Account Number:			
		Bank Name:			
		All Savings Account Balance's:	\$		
Child Support:	\$	Account Number:			
		Bank Name:	T		
Alimony:	\$	IRA's, Retirement Accounts, Stocks Bonds, CD's, 401k's Total Value :	\$		
SSI:	\$	Cash Value of Life Insurance:	\$		
Food Stamps:	\$	Available balance on all Credit Cards:	\$		
Family Support:	\$	Investments:	\$		
Retirement Pension:	\$	Personal Property Value:	\$		
Other Income:	\$	Other Assets	\$		
Other Income:	\$		\$		
Total Income:	\$	Total Assets:	\$		
To ensure the most complete and timely review - please enclose ALL applicable items from the following list: Note: Applications received with missing, invalid, or incomplete information will not be considered for review. ■ Completed application with all appropriate signatures: ■ Written description of how you (the patient) are supported by another party. ■ Copies of two (2) bills and cancelled check copies (showing expenses paid by another party) ■ Most recent Federal Income Tax Return: (all pages) ■ Enclosed □ No □ Yes					
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