De Silva Medical Group
PO Box 479, Villa Rica, GA 30801
(844) 475-3299
Fax: (404) 939-1848
contact@desilvamedgroup.com
www.desilvamedgroup.com

Please fill out this form completely and return to or your nearest **De Silva Medical Group** location, fax/mail to the above number or address or scan and email to submitdocuments@desilvamedgroup.com

Financial Assistance Application

Patient Information

• Full Name: _____

• Date of Birth: _____

• Phone Number: _____

• Cell phone Phone Number: _____

• Email Address: _____

• Home Address: _____

• City/State/ZIP: _____

Household Information

• Number of People in Household: _____

• Dependents (Names & Ages): _____
_____
_____
_____
If you need more space, write them on the back of the last page of this application.

• Marital Status: ☐ Single ☐ Married ☐ Divorced
☐ Widowed

Employment & Income

• Employer Name: _____

• Employer Address: _____

_____

• Job Title: _____

• Monthly Gross Income: _____

• Other Household Income (spouse, dependents, etc.): _____

• Total Household Monthly Income: _____

Expenses

• Monthly Rent/Mortgage: _____

Rent/Mortgage Paid to
:_____

• Utilities (electric, water, gas, etc.): _____

• Food/Groceries: _____

• Transportation: _____

• Medical Expenses: _____

• Other Expenses: _____

Insurance Information

• Do you or anyone in your household have health insurance? ☐ Yes ☐ No
If yes, who DOES have insurance?
_____
If no, skip the next two questions.

• Insurance Provider: _____
• Policy Number: _____

Assistance Requested

• ☐ Full Financial Assistance
• ☐ Sliding scale fee
• ☐ Payment plan
If you indicated payment plan, what is your desired payment arrangement?

Please explain why you are requesting financial assistance:
_____

_____

_____

Required Documentation

Please attach copies of the following (if applicable):

• Proof of income (pay stubs, tax return, unemployment benefits)
• Proof of residency (utility bill, lease agreement, letter from homeowner you stay with- one is required)
• Insurance card(s) (if applicable)
• Proof of identity (drivers license, state issued identification card, military identification card, passport, consulate identification card, university, or college issued identification card)

Certification & Signature

I certify that the information provided in this application is true to the best of my knowledge. I understand that lying on this application could result in denial or termination of the financial assistance program, and possibly a permanent ban from the program.

_____
Applicant Signature

_____
Applicants Printed Full Name

_____
Date Signed