For Assistance:
480-657-2500, option 5
Fax: 602-521-6221
Email: pfs@sdil.net

FINANCIAL ASSISTANCE DISCLOSURE

Thank you for completing the information below. In addition to the completed form, we will need a copy of last year's W2s, 2 most recent pay stubs, 2 current months of any/all bank statements and any other income/asset verifications, including 2 months of all investment accounts. Please return your application and supporting documentation as soon as possible to ensure timely processing.

PATIENT INFORMATION		
Patient Name	**Account– #**	**Estimate/Balance**
Date of Birth	**Relationship to Guarantor**	

GUARANTOR INFORMATION		
Name		**Date of Birth**
Address		**Phone**
City	**State**	**Zip**
Employer	**Length of Employment**	**Est Gross Income**
Income from Other Sources (eg. child support, alimony, retirement)		

SPOUSE INFORMATION		
Name		**Date of Birth**
Address		**Phone**
City	**State**	**Zip**
Employer	**Length of Employment**	**Est Gross Income**
Income from Other Sources (eg. child support, alimony, retirement)		

DEPENDENT INFORMATION		
Name (Last, First, Middle Initial)	**Relationship**	**Date of Birth**

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BANK INFORMATION		
Bank Name	**Checking Balance**	**Savings Balance**
Bank/Credit Union Name	**Checking Balance**	**Savings Balance**

I certify that the information provided in this financial disclosure worksheet and on any attachments is accurate and complete to the best of my knowledge. By signing below, I certify that I am unable to pay my SDI medical bill due to financial hardship. I understand I must update this information if requested and/or if my financial situation changes.

_____ _____

Applicant **Date**

☐ **Proof of income attached**

PROVIDER ONLY – DO NOT USE	
Total Annual Income	**Number in Family**
Total approved for charity/installments	**Date Determination Letter Mailed**
Authorization Level I	**Authorization Level II**