FINANCIAL ASSISTANCE PROGRAM APPLICATION

Please answer the questions below as completely as possible. All information will be kept completely confidential. If you have any questions or need assistance please call our office at 541.205.6750, Monday through Thursday 8 A.M. to 4 P.M.

Date | Patient's Name | Last | First | M.I.

Date of Birth / / | Telephone Number

Address | City | State | Zip

Persons Responsible for paying bill | Address | Telephone Number | Relationship to patient

Persons in household (including those under the age of 18) | Relationship | Date of Birth

HOUSEHOLD INCOME

Please provide the following information for each member of your household, if applicable
Attach verification of all types of income to this application to avoid application delays.

	Self	Other	Total
Wages, Salaries, Tips, etc. (Gross)			
Self Employment/ Business Income			
Unemployment Benefits, Workers' Compensation			
Social Security/ Pensions			
Government Assistance/Disability Income			
Total Income			

PLEASE ATTACH A COPY OF:

- ☐ Income Verification for the past 3 months for each person (in pay stubs)
- ☐ Wage records from employment office if no income
- ☐ Tax returns for the last 2 years

The above application is true to the best of my knowledge. If Connect Restore Thrive Counseling seeks verification of any information provided, I authorize any party contacted by Connect Restore Thrive to release any requested verification to Connect Restore Thrive.

Date: _____ Applicant's Signature: _____