MAXIMUM PERFORMANCE
PHYSICAL THERAPY & FITNESS

East Location: 426A McCall Road, Manhattan, KS 66502
785-776-0670/ Fax 785-776-0096
West Location: 4201B Anderson Avenue, Manhattan, KS 66503
785-539-5555/ Fax 785-539-4551

FINANCIAL INFORMATION FORM / FINANCIAL ASSISTANCE APPLICATION

INSTRUCTIONS - All Questions Must Be Answered. If a question does not pertain, write N/A on the line

* For assistance completing these forms or if you have any questions, please call 785-776-0670
* Applications will be rejected if they are not completed in full or requested documents are not attached
* Attach a photocopy of one proof of identity with a picture (ex. Driver's License or Passport with Photo)
* Please use the back of this form if you need additional room to list all information required
* Attach a photocopy of the following proofs of Income:

☐ Last two paycheck stubs ☐ Unemployment Benefits ☐ Social Security Check or Award Letter

PATIENT INFORMATION - All Questions Must Be Answered

Patient First Name (Full Legal Name)	Middle Name	Last Name		
Patient's Address	City		State	Zip
Home Phone	Cell Phone	Work Phone		
Sex M F / Date of Birth	Social Security Number	Marital Status	Number of Persons in Family	
Employer's Name			Employer's Phone #	
Employer's Address	City		State	Zip

Employment Status (check one) Full time ☐ Part time ☐ Unemployed ☐ Homemaker ☐ Unable to Work ☐

SPOUSE/OTHER INFORMATION - All Questions Must Be Answered

Spouse's First Name (Full Legal Name)	Middle Name	Last Name		
Address	City		State	Zip
Home Phone	Cell Phone	Work Phone		
Sex M F / Date of Birth	Social Security Number	Marital Status	Number of Persons in Family	
Employer's Name			Employer's Phone #	
Employer's Address	City		State	Zip

Employment Status (check one) Full time ☐ Part time ☐ Unemployed ☐ Homemaker ☐ Unable to Work ☐

DEPENDENTS/OTHER INFORMATION - All Questions Must be Answered

CHILDREN UNDER 18 AND OTHER DEPENDENTS IN THE HOUSEHOLD		Relationship of Dependents - Check One				
Full Name	Date of Birth	Child	Stepchild	Guardian	Adult/Senior	Not Related

Number of Claimed Dependents on Federal Tax Return

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HOUSEHOLD INCOME - Please Furnish Copies of Most Recent Federal Tax Return

1. Wages	$ /mo.	8. Retirement/Pension Income	$ /mo.
2. Other Wages	$ /mo.	9. Workers Compensation	$ /mo.
3. General Relief	$ /mo.	10. Awards from Settlements	$ /mo.
4. Social Security/SSI Disability	$ /mo.	11. Rents	$ /mo.
5. Aid to Dependent Children	$ /mo.	2. Student Work Study/Loan/Grants	$ /mo.
6. Alimony/Child Support	$ /mo.	3. Federal Entitlements	$ /mo.
7. Unemployment Income	$ /mo.	4. Other	$ /mo.

Do you have any individual retirement accounts? (IRA, 401(k), 401(b), Keogh)	☐ No ☐ Yes; current value is:	$
Do you receive income from interest, dividends, or investments?	☐ No ☐ Yes; total amount is:	$

If Unemployed, please provide previous sources and amounts of gross family income below:

Source

Amount

HOUSEHOLD EXPENSES PER MONTH

Housing: Rent ☐ Own ☐ Value of Property $

1. House Payment/Rent	$ /mo.	8. Alimony	$ /mo.
2. Utilities (Elec./Water)	$ /mo.	9. Child Support/Care/Tuition	$ /mo.
3. TV/Cable/Phone	$ /mo.	10. Health Ins. Premiums & Expenses	$ /mo.
4. Auto Payments	$ /mo.	11. Life/Disability Ins. Premiums	$ /mo.
5. Auto Insurance	$ /mo.	12. Home Ins. & Maintenance Fees	$ /mo.
6. Gas/Transportation Expense	$ /mo.	13. Credit Card Debt	$ /mo.
7. Food/Household Expense	$ /mo.	14. Miscellaneous Expenses	$ /mo.

CREDIT CARD DEBT:

Company	Balance	Monthly Payments	Limits
	$	$	$
	$	$	$
	$	$	$

MORTGAGE/LOANS:

Lender	Balance	Monthly Payments	Limits
	$	$	$
	$	$	$
	$	$	$

Do you own an automobile(s)? ☐ No ☐ Yes If Yes, please complete information below:

#1		#2		#3	
YEAR		YEAR		YEAR	
MAKE		MAKE		MAKE	
MODEL		MODEL		MODEL	
VALUE	$	VALUE	$	VALUE	$
PAYMENT	$	PAYMENT	$	PAYMENT	$
BAL. DUE	$	BAL. DUE	$	BAL. DUE	$

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BANK ACCOUNTS/OTHERS ASSETS (must answer all 3 questions):

Checking Account?	(circle one)	YES	NO	Current Balance:	$
Savings Account?	(circle one)	YES	NO	Current Balance:	$
Additional Property?	(circle one)	YES	NO	Current Value:	$

If YES, please describe:

ATTESTATION OF ACCURACY AND TRUTHFULNESS:

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- The information provided reflects HOUSEHOLD income and expenses.
- This information as well as a credit report and other publicly available information may be used by Maximum Performance Physical Therapy & Fitness to establish a payment plan and/or to determine eligibility for financial assistance.
- I give my consent to Maximum Performance Physical Therapy & Fitness to obtain information from any source to verify the statements I have made.
- You will receive written communication from Maximum Performance Physical Therapy & Fitness if the information provided is incomplete or insufficient to determine your eligibility for financial assistance or if you do not meet the eligibility qualifications. You will also be notified in writing if you are eligible for financial assistance. Allow up to 30 days for processing.
- Patients who apply for financial assistance may be eligible for funds from local, state or federal programs. Patients are expected to apply for such programs before a determination of eligibility for financial assistance. If a patient refuses to apply for, or follow through with an application for Medicaid or other coverage, the patient's Financial Assistance Application will be denied.
- I affirm to the fact that I have applied for all possible insurance coverage, including Medicaid, Crime Victims, Health Exchange Insurance and any other local, state or federal coverage. processing.
- I understand that if I do not qualify for financial assistance, I will be responsible for the cost of the care.

Patient/Guarantor:

Print Name	Signature of Patient or Responsible Party	Date

FOR PATIENT ACCOUNTS/BUSINESS OFFICE USE

ELIGIBILITY APPROVED ☐ **RATE** _____ **ELIGIBILITY DENIED** ☐ **REASON** _____

Print Name	Signature of Patient Accounts Manager	Date
Print Name	Signature of Director of Clinical Services	Date