

FINANCIAL HARDSHIP INFORMATION FORM

NAME: _____ AGE: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NO: _____ MEDICARE NO: _____

ADDRESS: _____

OCCUPATION: _____ DOCTOR: _____

**PLEASE FILL INFORMATION REQUESTED BELOW.
ALL INFORMATION WILL BE HELD CONFIDENTIAL BY Pumps It, Inc.**

MONTHLY INCOME: _____ SOURCE(S): _____

DO YOU OWN OR RENT YOUR HOME? OWN RENT MONTHLY PAYMENT _____

DO YOU OWN A VEHICLE? NO YES MONTHLY PAYMENT _____

PLEASE LIST AMOUNT OF ALL DEBTS THAT YOU OWE IN EXCESS OF \$100.00:

PLEASE LIST THE USUAL MONTHLY EXPENSES: UTILITIES: _____ FOOD: _____

CLOTHING: _____ MEDICAL: _____ TRANSPORTATION: _____

OTHER (SPECIFY): _____

ARE YOU ABLE TO PAY FOR ANY PORTION OF YOUR MONTHLY MEDICAL BILLS THAT ARE INCURRED THROUGH Pumps It, Inc?

DO YOU HAVE ANY INSURANCE COVERAGE? PLEASE LIST BELOW:

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED ON THIS FINANCIAL HARDSHIP INFORMATION FORM IS COMPLETE, TRUE AND ACCURATE.

CLIENT/PATIENT'S NAME (please print): _____

CLIENT/PATIENT'S SIGNATURE: _____

DATE SIGNED: _____