Financial Assistance Program

Date:

How to Apply:

In order for us to process your application, we must receive all documents indicated below within 30 days of the date on this letter. Any additional documents requested must be received within 15 business days of the request. All information received will remain confidential. Collection activity will continue on your account until your financial assistance status is determined.

Required Documents:

Completed and signed Financial Assistance Application
Copy of most recent Tax Return (if you do not have a copy, you may obtain one by calling the IRS at 1-800-829-0922)
AHCCCS denial if Self Pay
Two current pay stubs or Unemployment Verification for each adult living in the home
Two current months detailed checking/savings statements for each adult living in the home
Copy of W-2s if applicable
Copy of Social Security Benefit Statement or other proof of income *(includes retirement, disability, child support, alimony)*

Completing the Application is Not a Guarantee of Approval

Approval is based on verified annual household income and family size in accordance with the expanded Federal Poverty guidelines. Additionally, Financial Assistance may be reversed if you become eligible for any third party funding pursuant to ARS 33.931 et seq.

You will be sent a notification letter once your financial assistance status has been determined.

If you need further assistance or have questions, please contact one of our Financial Assistance Counselors at 623-931-3488 between the hours of 8:00 am and 5:00 pm, Monday through Friday.

Southwest Diagnostic Imaging, Ltd.
Financial Assistance Department
2323 W Rose Garden Lane|Phoenix|AZ|85027
Phone 623-931-3488|Fax 623-931-4675|Email fap@sdil.net

SDI SOUTHWEST DIAGNOSTIC IMAGING LTD

PATIENT NAME:______________________________

ACCOUNT: ____________________

FINANCIAL DISCLOSURE WORKSHEET

PATIENT LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY #	BIRTHDATE
MAILING ADDRESS			HOW LONG?	PHONE
CITY		STATE	ZIP CODE	

PATIENT EMPLOYER NAME	ADDRESS	PHONE	NET MONTHLY PAY
IF PATIENT UNEMPLOYED: NAME OF LAST EMPLOYER (NAME & ADDRESS)			LAST EMPLOYMENT DATE
SPOUSE/RESPONSIBLE PARTY LAST NAME, FIRST	MIDDLE	SOCIAL SECURITY #	BIRTHDATE
ADDRESS IF DIFFERENT THAN PATIENT			
SPOUSE/RESPONSIBLE PARTY EMPLOYER NAME	ADDRESS	PHONE	NET MONTHLY PAY
IF SPOUSE/RESPONSIBLE PARTY UNEMPLOYED: NAME OF LAST EMPLOYER (NAME & ADDRESS)			LAST EMPLOYMENT DATE

	CURRENT HOUSEHOLD FAMILY MEMBERS	BIRTHDATE	RELATIONSHIP	EMPLOYED BY	NET MONTHLY PAY (PROVIDE PAYSTUBS, STATEMENT ETC)
1					
2					
3					
4					
5					

OTHER MONTHLY INCOME:	$	SPECIFY SOURCE:

EXPENSES	PRESENT BALANCE	MONTHLY PAYMENT	ASSETS	BALANCE OF ACCOUNT
RENT/MORTGAGE (+HOA IF APPLICABLE) RENT OWN			BANK NAME:	
UTILITIES (ELECTRICITY, GAS, WATER)			CHECKING	
FOOD			SAVINGS OR CERTIFICATE	
PHONE			ASSETS CONTINUED	CURRENT VALUE
CABLE/INTERNET			AUTO (YEAR & MAKE)	
AUTO LOAN(S)			AUTO (YEAR & MAKE)	
INSURANCE			RESIDENCE-MARKET VALUE	
CREDIT CARDS			INSURANCE – CASH VALUE	
OTHER (IE: Insurance Payments, Child Support, Alimony etc. PLEASE EXPLAIN			OTHER ASSETS (DESCRIBE	
TOTAL EXPENSES			**TOTAL ASSETS**	

PLEASE COMPLETE AND SIGN THE NEXT PAGE

MEDICAL EXPENSES (ENTER ONLY EXPENSES FOR WHICH THE PATIENT OR RESPONSIBLE PARTY IS ENTIRELY LIABLE FOR PAYING)	PRESENT BALANCE	MONTHLY PAYMENT
PHYSICIAN BILLS (PLEASE ITEMIZE)		
HOSPITAL/HEALTHCARE FACILITY BILLS (PLEASE ITEMIZE)		
PRESCRIPTION DRUG COSTS (PURCHASED ON A RECCURING BASIS)		
EYE CARE BILLS		
DENTAL BILLS		
OTHER MEDICAL BILLS/EXPENSES (PLEASE ITEMIZE)		

COMMENTS:

I CERTIFY THAT ALL STATEMENTS MADE IN THIS FINANCIAL STATEMENT ARE TRUE AND COMPLETE TO THE BEST OF MY ABILITY.

SIGNATURE	DATE

PLEASE RETURN IN ENCLOSED ENVELOPE OR MAIL TO:
SOUTHWEST DIAGNOSTIC IMAGING LTD, 2323 WEST ROSE GARDEN LANE, PHOENIX AZ 85027

FOR ASSISTANCE COMPLETING THIS APPLICATION, PLEASE CALL FINANCIAL ASSISTANCE DEPARTMENT AT 623-931-3488