HEALTHY ASIANS
& PACIFIC ISLANDERS
MEDICAL CENTER

HEALTHCARE FINANCIAL ASSISTANCE SCHOLARSHIP APPLICATION

This application allows Healthy Asians & Pacific Islanders Medical Center to share your information with the Asian Community Development Council in order to complete your enrollment to qualify for a healthcare scholarship. Please note, if you have Medicare coverage of any kind, you will NOT be eligible for enrollment. Please complete this Healthcare Financial Assistance Scholarship Request Form in its entirety.

First Name:_____Last Name: _____ MI:_____

Address: _____ City: _____ State:_____

Zip Code: _____ Phone: _____ Email: _____

Date of Birth: _____ / _____ / _____ Last 4 Digits of SSN: _____ Household Size: _____

Language Spoken at Home: _____ Household Monthly Income (Gross Income):_____

DECLARATION OF FINANCIAL HARDSHIP:

I _____, declare by my signature below, that I am financially unable to pay my financial obligation to Health Asians & Pacific Islanders Medical Center for healthcare services that have been rendered. I further state that the balance for which my insurance company does not cover (co-pays, co-insurance, or calendar year deductible) if a financial burden and therefore request enrollment into Asian Community Development Council Healthcare Financial Assistance Scholarship Program. My financial hardship is due to:

_____

_____

_____

_____

I understand that I may be subjected to an audit by the Government Accounting Office (GAO) and/or the Internal Revenue Service (IRS) for verification of this information.

Date: _____ / _____ / 20_____

Signature: **X**_____ Print Name:_____
Patient

Signature: **X**_____ Print Name:_____
Legal Guardian if Patient is under 18

Date Application was Reviewed: _____ / _____ / 20_____

Initial of Reviewer: _____

8863 W Flamingo Rd Suite 101 Las Vegas NV 89147 Office: (702) 485-3888 Fax: (725) 299-1115 Email: info@hapimedical.org