FINANCIAL ASSISTANCE APPLICATION

All Information is subject to verification and EPPA may contact you for additional supporting documentation. Information contained in the application will remain strictly confidential.

PERSONAL HISTORY	
***Annual Income :**	**Account Number:**
*Please attach income documentation with application: **Two most recent pay stubs *or* most recent federal income tax form 1040**	**Patient Name:**
	Address:
Family Size:	**City:** **State:** **Zip Code:**

MONTHLY EXPENSES	
Mortgage/Rent:	**Utilities:**
Insurance:	**Loans:**
Car Payments:	**Credit Card Payment:**
Groceries:	**Gas:**
Other:	

OTHER EXTENUATING CIRCUMSTANCES
Signature: **Date:**

In order to be considered for EPPA's financial assistance program, please provide the requested information within 10 business days. Once this information is received and processed, you will be notified of our decision regarding the outcome of your application.

Thank you,

Patient Financial Services
Emergency Physicians, PA
Phone: 952-857-1500
Fax: 952-835-4403
Email: PFS@EPPAhealth.com