PATIENT ASSISTANCE FUND (PAF)

The Patient Assistance Fund (PAF) helps patients access essential medical, dental, and behavioral health services with a self-pay balance not covered by insurance, ensuring care regardless of a financial situation.

To apply, the applicant must complete an official Patient Assistance Fund application at a clinic location or submit the application electronically with all necessary supporting documents directly to PAF@elevatedch.org. The submission must include the following required materials:

Requirements:

1. **Completed Patient Assistance Fund (PAF) Application.**
2. **Proof of identification for each family member living in the same household**. Provide proof of identification for each member of the household. Accepted documents include a driver's license, birth certificate, passport, etc. A photo ID is preferred for adults. Household members include:
   - Husband, wife, common-law spouse, or civil union partners
   - Children, stepchildren, or foster children under the age of 18
   - Adult children (over 18) with disabilities who are still in high school or higher education and living full-time in the household (must provide student ID)
   - Dependent parents
3. **Proof of Patient or Family Income.** Provide documentation of income for the last calendar month or year. Acceptable documents include:
   - Paycheck stubs from the last calendar month (either 2 consecutive biweekly pay stubs or 4 consecutive weekly pay stubs)
   - Current income tax forms or W-2s
   - Income verification letter from the patient's employer

     If employment income is paid in cash, an employer's income verification is required.

     For the employer's income verification letter, it should:
     - Be typed and on company letterhead and dated within the last 30 days
     - Include the employer's address, phone number, and contact person
     - Specify the employee's gross income and, if applicable, estimated tips

   If the patient is self-employed, they must provide one of the following:
   - Taxes
   - Profit and Loss worksheet
   - One month of gross business bank deposits or a ledger
   - Elevated Community Health Self-employment worksheet

   If the income is derived from unearned sources, it may include:
   - Unemployment benefits or Worker's Compensation
   - Social Security or Supplemental Security Income (SSI)
   - Pension or retirement income
   - Public assistance (e.g., SNAP, TANF)
   - Veterans' benefits or Survivor benefits
   - Disability benefits
   - Income from interest, dividends, rents, royalties, estates, or trusts
   - Alimony
   - Child support

   Note: All income from spouses, significant others, and other members of the same household must be declared.

4. **Any outstanding Elevated Community Health bills that have been incurred on or after January 1, 2025, that you require financial assistance for**.

"The application will be processed within two weeks, and you will be contacted upon completion".

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APPLICATION FORM

Applicant information			
Full Name			
DOB	Month_____ Day_____ Year _____	Phone #	
Address		City, State, Zip Code	

Household information

Full name Partner/ Spouse and kids under 18 years old	**DOB**	**Relationship to Applicant**	**Has Outstanding Bill**
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐

Financial Hardship Information:

Please briefly describe your current hardship:

Appointment Information:

Appointment Date	
Cost of Appointment/Procedure	$

Applicant Signature	Date: