CLM Center for Life Management

Request for Charitable Care Assistance Application

REQUIRED

Which medically necessary service(s) is requested? _____

List medical justification or barriers to support requested services: _____

_____

_____

List frequency requested? i.e., weekly, monthly _____

2023 Financial Assistant Poverty Guidelines		100% Discount	75% Discount	50% Discount
Family Size	2023 FPG	Income less than or equal to 200% of FPG	Income of 201% - 300% of FPG	Income of 301% - 400% of FPG
1	$14,580	0 - $29,160	$29,161 - $43,740	$43,741 -$58,320
2	$19,720	0 - $39,440	$39,441 - $59,160	$59,161 - $78,880
3	$24,860	0 - $49,720	$49,721 - $74,580	$74,581 - $99,440
4	$30,000	0 - $60,000	$60,001 -$90,000	$90,001 - $120,000
5	$35,410	0 - $70,820	$70,821 - $106,230	$106,231 - $141,640
6	$40,280	0 - $80,560	$80,561 - $120,840	$120, 841 - $161,120
7	$45,420	0 - $90,840	$90,841 - $136, 260	$136,261 - $181,680
8	$50,560	0 - $101,120	$101,121 -$151,680	$151,680 - $202,240

Required Documents
Past 3 months of bank (checking, savings) and/or investment fund statements from the financial institution.
3 most recent pay stubs from each worker. If pay stubs are unavailable, provide written verification from the employer on company letterhead stating gross income earned and hire date. If you receive no income at all provide written statement as to who is supporting you.
Copy of Social Security or pension check, or bank statement showing direct deposit.
If you receive assistance such as food stamps, fuel assistance, Medicaid, rent send copy of approval letter or vouchers from programs for which you have been approved.

Client Name:	Phone:	Email:
Address:	Date of Birth:	Client #:
Guarantor:	Relationship:	
Employer:	Title:	Years Employed:
Spouse's Name:		Spouse Phone:
Spouse's Employer:	Title:	Years Employed:
Insurance Carrier:		Policy #:
Health Insurance Offered by Client or Spouse's Employer Yes No		
Are you pending Medicaid insurance? Yes No Date Applied_____	Did you meet with a CLM Benefit Specialist? Yes No	

Asset Accounts	**Description**	**Amount**
Checking Account		$
Savings Account		$
Other Accounts		$
	Total	$

Income			
Gross Wages	$	Unemployment Compensation	$
Spouse's Wages	$	Workman's Compensation	$
Public Assistance	$	Child Support/Alimony	$
Social Security	$	Other (explain)	$
Disability	$	Other (explain)	$
		Total	$

I attest that the information contained above is complete, true, and accurate without any material omissions. I agree to provide all required supporting documentation. I authorize CLM to verify all contained information for the sole purpose of establishing financial need. Applicant/Responsible Party Signature: _____ Date: _____