Health Care Financial Assistance Application

Please include 2 of your most recent paycheck stubs, SNAP, SSI, TANF benefit documents with this application

Email documents to info@mosaictherapy.org or fax to (888) 975-8519

Processing will take 15 business days

Please state amount you are able to pay on a weekly basis for at least 12 weeks

$5 (minimum)_____

Patient Name_____

Date of Birth _____

Address _____ City _____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Email _____

Single Married/Significant Other Divorced/Separated Widow/Widower

Responsible Party Name _____ Relationship _____

Date of Birth _____

Address _____

Home Phone # _____ Cell Phone # _____

Name(s) and age(s) of dependents living with you for whom you are responsible. Please include DOB:

_____

_____

_____

_____

_____

_____

_____

_____