|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  **Financial Solvency Information** | | | | | APPLICATION NUMBER | |
| FACILITY TYPE | |
| **Facility Information** | | | | | | | |
| FACILITY NAME | | | | BUSINESS STRUCTURE TYPE | | | |
| FACILITY ADDRESS CITY STATE ZIP CODE | | | | | | | |
| EMAIL ADDRESS | | | | CELL PHONE NUMBER (INCLUDE AREA CODE) | | | |
| **Additional Licenses Held** | | | | | | | |
| FACILITY NAME | | | | | | | LICENSE NUMBER |
| FACILITY NAME | | | | | | | LICENSE NUMBER |
| **Delinquent Account Information (Completed by Applicant)** | | | | | | | |
| For the purposes of determining financial solvency, debt becomes delinquent when it has not been paid for more than 30 days beyond the date it was due. | | | | | | | |
| LIST BELOW YOUR DELINQUENT ACCOUNTS | | | OUTSTANDING BALANCE AMOUNT | | WHAT IS THIS FOR (CREDIT CARD, MORTGAGE, ETC.)? | | |
|  | | | **$** | |  | | |
|  | | | **$** | |  | | |
|  | | | **$** | |  | | |
|  | | | **$** | |  | | |
|  | | | **$** | |  | | |
|  | | | **$** | |  | | |
|  | | | **$** | |  | | |
|  | | | **$** | |  | | |
|  | | | **$** | |  | | |
| TOTAL AMOUNT DUE | | | **$** | |  | | |
| **Written Statement** | | | | | | | |
| Provide a brief statement as to why you were unable to pay your delinquent account(s). | | | | | | | |
| **Intent to Pay Back “Medical Delinquent Account(s) Only”** | | | | | | | |
| Provide a brief statement if you are making payments towards the delinquent medical account(s). If you have established a re-payment plan, please provide a copy. If you have delinquent debt not related to medical debt, you have two options: 1) Withdraw your application; or 2) Resolve your delinquent account(s). Payment arrangements are only acceptable for medical debt. | | | | | | | |
| **I attest that the information provided is accurate and/or true. Failure to provide the required information could result in the application being voided and/or offered to be withdrawn.** | | | | | | | |
| SIGNATURE OF PERSON COMPLETING FORM DATE | | | | | | | |
| **Business Analysis and Applications Unit Use Only** | | | | | | | |
| MEETING DATE | | DEPARTMENT REVIEW DECISION | | | | | |
| ADDITIONAL INFORMATION IF NEEDED | | | | | | | |
| DATE ENTERED INTO FMS | | STAFF NAME | | | | | |