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|  | 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 Failure to provide the required information could result in the application being voided and/or offered to be withdrawn.** |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 |