Application Requirements Checklist

Please review the following checklist carefully and complete or attach all items that apply to you.
Provide as much information as you can to make your application review easier and faster.

☐ Completed Application – pages 2-14

Attachments:

☐ Identification – Must be a current, picture ID.
Submit a copy of one of the following: Driver's License, State Issued ID, Voter ID, Salvation Army ID

☐ Social Security Card – Copy of your card is preferred.
If you do not have your social security card, an official Federal or State tax document with your social security number on it will be acceptable.

☐ Tax Information

If You Do Not File Taxes:

- ☐ Form 4506-T – Must be signed and submitted. Form found on page 16 of packet.

If You File Taxes:

- ☐ Income Tax Return – Form 1040, pages 1-2 of your most recent return.
  Prior to April 15, previous year's return is acceptable. After April 15, the most recent year's return is required.

☐ Income/Financial Information – Must include income information for entire household.

Zero Income – Provide ONE of the following:

- ☐ Notarized letter signed by someone who financially assists you – Form found on page 15 of packet.
- ☐ Food Stamp Letter

If You Have Income, Include Any That Apply to You:

- ☐ Benefits letter (ex. SSI, unemployment, food stamps, housing voucher, other government benefits) – Must be current and list your name and monthly amount.
- ☐ Proof of Child support/Alimony payments that you receive
- ☐ Most recent bank statement – Must list your name and beginning and ending balance.

Once complete, the application can be returned by mail, email, or hand delivery.
Please do not fax.

MAIL: Medical Outreach Ministries
Attention: Henry Llorens
5741 Carmichael Pkwy
Montgomery, AL 36117

EMAIL: henry.llorens@med-outreach.org

Questions?: Call (334) 281-8008

Application for Eligibility

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Race: _____ Ethnicity (*circle*): Hispanic Non-Hispanic

County of Residence: _____

Income

Are you currently working? (*circle*) NO YES

Total income per month (*include all sources – job, SSI, food stamps, etc.*): $ _____

How many people are in your household? (*circle*)

1 2 3 4 5 6 7 8 9 Other_____

Insurance

Do you have Medicare? (*circle*) NO YES IF YES, Part A Part B

Do you have Medicaid? (*circle*) NO YES IF YES, Full Medicaid Family Planning Only

Do you have VA benefits? (*circle*) NO YES

Do you have Private Insurance? (*circle*) NO YES IF YES, Company Name: _____

Are you currently seeing a doctor? (*circle*) NO YES IF YES, Doctor Name: _____

Patient Financial Assistance Application

(Please Print)

Date: _____

Patient Information

Name: _____ SOCIAL SECURITY #:_____
(Last) (First) (MI)

Marital Status: Married_____/ Single_____/ Divorced_____/ Widowed_____/ Separated_____

How long have you lived in Alabama? _____ D/O/B: _____/_____/_____
(mm/dd/yyyy)

Present Address: _____
(Street/Apt Number) (City) (State) (Zip)

Previous Address: _____
(Street/Apt Number) (City) (State) (Zip)

Telephone Number: (_____) _____ (_____) _____ (_____) _____
(Home) (Work) (Cell)

Email address _____ Can we text you at your cell number? _____

Responsible Party Information (If patient is under 19 years of age.)

Name: _____ D/O/B: _____/_____/_____
(Last) (First) (MI)

Present Address: _____
(Street/Apt Number) (City) (State) (Zip)

Previous Address: _____
(Street/Apt Number) (City) (State) (Zip)

Telephone Number: (_____) _____ (_____) _____ (_____) _____
(Home) (Work) (Cell)

Relationship to Patient: _____ SOCIAL SECURITY #:_____

List all persons to be included in application process: *Please read instruction # 5 on the cover letter of the Financial Assistance Application packet before completing this section and ensure that you provide Annual Income of all earning family members.*

	Name	DOB	SS#	Annual Income
Applicant				
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				
Dependent				

(Please list any additional legal dependents along with proof such as court order on separate sheet if applicable.)

Patient Financial Assistance Application

Name: _____
(Please Print) (Last) (First) (MI)

Please ensure that you provide proof of all information that you input in the sections below under Income, Assets, and Governmental Programs/ support. Please input N/A against items that do not apply to you.

INCOME			ASSETS	
Description	Monthly Income		Description	Value Amount
Gross Salary for Applicant	$		Home (Recent Appraised Value)	$
Employer Name:			Checking Account (Provide Current Month's statement)	$
Gross Salary for Spouse	$		Name of Bank(s)	
Employer Name:			Savings Account (Provide Current Month's statement)	$
Gross Salary for any other Family member less than 18 years of age	$		Name of Bank(s)	$
Gross Salary for any other Family member over 18 years	$		IRA (Provide copy of certificate)	$
Dividend and Interest	$		Other	$
Rental Income	$		TOTAL ASSETS	$
Pension Income	$			
Alimony (Income)	$		Complete if you do not show income or assets	
Social Security Benefits	$		Food Stamps	
V.A. Benefits	$		Housing subsidy	
Income from estates, trusts	$		HUD	$
			Section 8	$
Other-	$		Utilities	$
TOTAL INCOME PER MONTH	$		Help from relative, friends, or others to cover expenses such as Rent, Car, Apartment etc.	$

I provide my consent and understand that the information I submit is subject to verification by Baptist Health and subject to review by state and/or federal enforcement agencies, , and other entities as required by law. I also understand that Baptist Health reserves the right to ask for additional information.

I certify under the statutes of perjury that the information on these pages is true and correct, and that I do not have the financial means to pay for medical care rendered to the above patient. If my financial situation changes in the upcoming calendar year, I will report these changes to the Baptist Health immediately.

*My signature on this application verifies that if I am entitled to any other medical benefits, including, but not limited to, a supplemental insurance policy, I will provide Baptist Health with this information and understand that if I choose not to give any information regarding my supplemental insurance carrier, my application for assistance could be denied and I will be responsible for the total amount of all outstanding bills at Baptist Health. I read and understand what is not covered by financial assistance and I cannot request a further review/audit of my charges once financial assistance is approved.
*Financial Assistance does not include Medications prescribed for patients to self-administer upon discharge.

I give Baptist Health permission to email me (if email is provided) my approval/denial letter.

Signature of Responsible Party: _____ Date: _____

Patient Financial Assistance Application Name: _____
(Please Print) (Last) (First) (MI)

Insurance Information:

Do you or your spouse have health insurance (Yes_____/No_____)? If so, list below:

	Insurance Company	Policy #	Group #
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Is health insurance available to you through your employers? Yes_____ No _____ N/A_____

Have you declined health insurance coverage offered to you by your employer or through responsible person's employer? Yes_____ No _____ N/A _____

Have you received or do you expect to receive a Third Party Liability settlement related to an accident or injury resulting in your admission to Baptist Health? Yes_____ No _____

If your visit at Baptist Health is the result of an accident or injury, are you represented by an attorney? Yes_____ No _____

If "Yes," please complete the following:

Attorney Name: _____

Attorney Address: _____

_____

Attorney Telephone: _____

My signature below attests that the above information is valid and true.

Signature of Responsible Party: _____ **Date:** _____

Patient Financial Assistance Application Name: _____
(Please Print) (Last) (First) (MI)

Financial Assistance does not cover the following services:

- **Copays**
- **Reconstructive surgery which is not medically necessary**
- **Cosmetic surgery**
- **Breast implants**
- **Breast reduction**
- **Teeth extractions (excluding radiation, transplant patients or extractions due to trauma.)**
- **Weight loss surgery**
- **Genetic testing that is required for determining treatment will be covered, but all other genetic testing will be charged to the patient.**
- **Medications prescribed for patients to self-administer upon discharge.**
- **Durable medical equipment**
- **Routine Physical Exams**
- **Services not normally covered by health insurance**

These are examples of services not covered under Financial Assistance Program. This list may not include all exclusions to the program.

Should you have questions regarding your particular plan of care, please feel free to call our office at (334) 747-4270.

We reserve the right to change or update covered or non-covered services without notice.

My signature below verifies that I have read and understand the list and statements stated above.

Signature of Responsible Party: _____ Date: _____

HIPAA – MEDICAL INFORMATION RELEASE

Federal privacy guidelines under HIPAA require a medical release of information on file for each patient.

This authorizes Medical Outreach Ministries to release medical information to designated family members or caregivers.

It also allows release of medical and financial information to pharmacies, hospitals, emergency medical personnel, and referral specialists for treatment, payment, or health care operations.

Your signature allows us to share your health information, after proper identification, to those you have identified and if indicated at specified locations for such things as appointment and medicine pickup reminders.

Your signature also acknowledges that you are aware of the posted Notice of Privacy Practices in our waiting room and understand copies are available if you would like to have one.

Complete Section A OR Section B:

Section A:

List the name, date of birth, and telephone number of each of the authorized individuals below.

I, _____, (*Patient name)* give my authorization to the following individual(s) listed below to discuss my medical care with the staff or volunteers at Medical Outreach Ministries on my behalf.

Name	Date of Birth	Phone #

Please list any health information you do not wish to be released or any other specifics regarding release of information:

_____

_____

_____

Section B:

I, _____, (*Patient name)* do not give my authorization to discuss my medical care with anyone other than myself.

A signed copy of this document will be provided to you and will be placed in your medical record. You can update the information on this document at any time to maintain accuracy.

Patient Signature: _____ Date: _____

ALABAMA CHARITABLE IMMUNITY LEGISLATION

The Volunteer Service Act

&

Volunteer Medical Professional Act

Medical Outreach Ministries is covered by the following State Laws:

- The Volunteer Service Act – AL Code Section 6-5-336
- Volunteer Medical Professional Act – AL Code Section 6-5-663

These state laws give limited immunity against lawsuits to all volunteers serving at Medical Outreach Ministries.

You can ask for a copy to further educate yourself on the charitable immunity laws of Alabama. The information is also posted on the Medical Outreach Ministries website at www.momclinic.org.

Your signature below indicates you have been made aware of the existence of these laws.

Patient Signature: _____ Date: _____

PATIENT'S RIGHTS AND RESPONSIBILITES

1. Patients are responsible for giving truthful personal, financial, and medical information. A patient who does not re-screen at the appropriate time cannot receive treatment until they have been re-screened for eligibility.
2. Patients will be responsible for keeping the clinic informed of any change in address, telephone numbers, income, or insurance status. To receive treatment at the clinic you cannot have any type of insurance, which includes Medicare, Medicaid, commercial insurance, or VA benefits.
3. Patients have the right to expect that their treatment and medical records will be kept confidential unless a proper release has been given. Please see the posted HIPAA "Notice of Privacy Practices."
4. Patients have the right to expect that their primary care will be provided by the clinic. When a patient goes to another facility without a Medical Outreach Ministries referral, they are responsible for charges incurred.
5. Medical Outreach Ministries does not perform examinations or complete paperwork for disability determination claims.
6. Patients are responsible for maintaining an appropriate and courteous attitude with clinic staff and volunteers. This responsibility extends to the offices of specialists who see MOM patients on a referral basis. Abusive behavior and/or inappropriate language will result in dismissal from the clinic.
7. Patients are not to bring anyone to the clinic who is under the influence of alcohol/illegal substances.
8. **Patient Initials**_____ Patients are subject to random drug testing or testing ordered by his or her provider. Refusal by a patient to submit to drug testing or discovery of legal or illegal drug abuse by a patient may result in dismissal from the clinic.
9. **Patient Initials**_____ For Medication Refill Requests, patients must give the clinic 7-10 days to complete a refill. Medications may not be refilled or replaced if patients are out of screening or if it is too soon to be refilled (based on last fill date). Exceptions will be diabetic, high blood pressure, seizure, asthma, or antibiotic medications.
10. **Patient Initials**_____ Patient non-compliance (not following physician instructions, not getting lab work done, not getting x-rays done, etc.) may result in dismissal from the clinic.
11. **Patient Initials**_____ Patients must adhere to the following **No-Show Policy**:
    a. A No-Show appointment is any appointment where a patient either does not show up (or login/answer for a telehealth appointment) or cancels on the day of the appointment.
    b. The No-Show policy applies to all types of appointments in the clinic: medical, counseling, diabetes education, physical therapy, case management, etc., whether in-person or through telehealth.
    c. Patients are responsible for being on time for their appointments.
    d. After 3 No-Show appointments at the clinic, a patient will receive a warning letter.
    e. After a 4th No-Show appointment at the clinic, a patient will receive a termination letter.
    f. After 1 No-Show appointment at an outside specialist referral, a patient will receive a termination letter.
    g. If a patient cancels an elective surgical procedure with less than 48 hours' notice for an outpatient procedure or less than 72 hours for a total joint procedure, the patient will receive a termination letter.
12. **Patient Initials**_____ Any patient who receives a termination letter will be dismissed from the clinic for one year.

I understand my patient rights and responsibilities as a patient of Medical Outreach Ministries.

Patient Signature: _____ Date: _____

MEDICAL BILLING POLICY

Medical Outreach Ministries does not pay medical bills.

Your Baptist Charity Care letter will list the amount of coverage you are to receive from Baptist Charity Care along with any applicable copay. If you are referred to a Baptist Hospital for lab tests or imaging or to a provider who practices under Baptist Charity Care, you will be expected to pay your copay as outlined in your Baptist Charity Care letter.

There are many free services that MOM can provide but be aware that some providers may bill you for their services. The time to ask about billing is at the time of your procedure or visit is being scheduled.

Medical Outreach Ministries may refer you to other physicians or dentists and ask for 100% charity write-off, a discount, or some type of payment plan for your procedure or visit. The amount of discount or benefit given is at the discretion of the physician or office taking the referral. If you cannot afford an applicable charge, please alert MOM prior to your appointment.

YOU MAY RECEIVE A BILL FOR OTHER CHARGES SUCH AS ANESTHESIA OR RADIOLOGY BECAUSE THEY ARE PROVIDED THROUGH AN OUTSIDE CONTRACT AT BAPTIST HEALTH.

If you get a bill that you do not understand:

- Call the provider who sent the bill and ask them if you can receive a discount since you are Baptist Charity Care and Medical Outreach Ministries patient.
- If their office does not give a discount, you are responsible for the entire bill.
- If they have forgotten to give you a discount, they should correct your bill at the time of your call. You will then owe the corrected balance.

Please do not tell any providers or hospitals that Medical Outreach Ministries will be responsible for your medical bills.

I understand the medical billing policy of Medical Outreach Ministries.

Patient Signature: _____ Date: _____

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Name: _____Date of Birth: _____

__Release to: Medical Outreach Ministries
5741 Carmichael Pkwy
Montgomery, AL 36117
PH: (334) 281-8008
FAX: (334) 558-0357

From: _____
_____
_____
Ph: _____
FAX: _____

__Release from: Medical Outreach Ministries
5741 Carmichael Pkwy
Montgomery, AL 36117
PH: (334) 281-8008
FAX: (334) 558-0357

To: _____
_____
_____
Ph: _____
FAX: _____

Information Requested:

____All health care information

____Immunization Record

____Other: _____

_____

This authorization is valid for this certification period, not to exceed 12 months from the date of signing.

By signing this authorization, I authorize the use and disclosure of the protected health information requested. I further understand that the information may be re-disclosed by the recipient and may no longer be protected by the HIPAA privacy rule. I have the right to revoke this authorization, except to the extent that Medical Outreach Ministries has acted with reliance upon this authorization.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

Name of Participant(s):_____ ____Race _____Male ___Female

_____ ____ Race ____Male ___Female

Head of Household:_____ ____Race ____Male ___Female

Address: _____

_____

Using table below, please indicate total annual income of all members of your household. This includes wages, retirement, child support, social security, disability, etc. First, determine household size number in the first column. Then, select one of the three annual household income options going across **on the same line.**

Household Size (Including Yourself)	Extremely Low Income	Very Low Income	Low Income
☐ 1 Person	☐ $0 up to $15,650	☐ $15,651 up to $26,050	☐ $26,051 up to $41,650
☐ 2 Persons	☐ $0 up to $17,850	☐ $17,851 up to $29,800	☐ $29,801 up to $47,600
☐ 3 Persons	☐ $0 up to $20,100	☐ $20,101 up to $33,500	☐ $33,501 up to $53,550
☐ 4 Persons	☐ $0 up to $22,300	☐ $22,301 up to $37,200	☐ $37,201 up to $59,500
☐ 5 Persons	☐ $0 up to $24,100	☐ $24,101 up to $40,200	☐ $40,201 up to $64,300
☐ 6 Persons	☐ $0 up to $25,900	☐ $25,901 up to $43,200	☐ $43,201 up to $69,050
☐ 7 Persons	☐ $0 up to $27,700	☐ $27,701 up to $46,150	☐ $46,151 up to $73,800
☐ 8 Persons	☐ $0 up to $29,450	☐ $29,451 up to $49,150	☐ $49,151 up to $78,550

I understand that State and Federal Law prohibits intentional or willful false statements or misrepresentations concerning financial position or household size. I fully understand that making intentional or willful false statements or misrepresentations is punishable by fine and/or imprisonment. I further understand that any intentional or willful false statements or misrepresentations of information will be grounds for disqualification to participate in the activity funded by the City of Montgomery through the U.S. Department of Housing and Urban Development (HUD). I certify that all of the information provided is true and exact to the best of my knowledge and belief.

_____ _____

Signature Date

☐ Applicant OR ☐ Parent/Guardian **(Check One)**

REV. 6/15/23

Medical Outreach Ministries
Medical History

Please answer these questions so we can help you be **as healthy as you can be**.

Name: _____ Today's Date: _____

Date of Birth: _____ Social Security Number: _____

Occupation: _____ Last Grade Completed in School_ _____ Married: ____ Single: ____

LIST ANY DRUG ALLERGIES	***FAMILY HISTORY***					
	Please check the box to the right if any family member has had the following:	Father	Mother	Father's Parents	Mother's Parents	Other
	Heart disease					
	High blood pressure					
	Stroke					
LIST CURRENT MEDICATIONS, including those not prescribed by a doctor	Cancer					
	Glaucoma					
	Diabetes					
	Epilepsy/convulsions					
	Bleeding					
	Kidney disease					
	Thyroid disease					
	Mental Illness					
( ) If you need more space, check here and list your other medications on another piece of paper.	Osteoporosis					

HOSPITALIZATIONS OR SURGERIES

Reason	***Date***	***Reason***	***Date***

WOMEN ONLY: Are you pregnant? ( ) Yes ( ) No Are you planning a pregnancy? ( ) Yes ( ) No

Date of your last mammogram: _____ Date of your last Pap smear: _____

YOUR PERSONAL MEDICAL HISTORY

Check all that apply. If you have diabetes, please complete the back of this form.

( ) Headaches
( ) Shortness of breath
( ) Heart palpitations
( ) Heart murmur
( ) Chest pain
( ) Dizziness / fainting
( ) Peripheral vascular disease
( ) Allergies / hay fever
( ) Asthma
( ) Bronchitis
( ) Pneumonia
( ) Ulcer
( ) GI disorder
( ) Early morning awakening
( ) Daytime drowsiness
( ) Difficulty falling asleep

( ) Lactose intolerance
( ) Gallbladder disease
( ) Renal disease
( ) Prostate disease
( ) Bowel irregularity
( ) Incontinence
( ) Sexual / menstrual dysfunction
( ) Venereal disease
( ) Frequent infections
( ) Hepatitis
( ) Anemia
( ) Arthritis
( ) Osteoarthritis
( ) Hearing loss
( ) Problems with reading or vision loss
( ) Snoring

( ) Nervousness
( ) Depression
( ) Gout
( ) Scarlet fever
( ) Chronic rashes
( ) Rheumatic fever
( ) AIDS / HIV
( ) Past stroke
( ) Diabetes – SEE BACK OF FORM
( ) Past heart attack
( ) Date of last tetanus shot:
( ) Date of last flu shot:
( ) Date of last pneumonia vaccine:

What exercise do you enjoy?

How often do you exercise?

What prevents you from exercising?

Do you smoke? ( ) Yes ( ) No
How long have you smoked? ____ Years
How many packs per day? _____
Are you interested in quitting? ____

Do you drink? ( ) Yes ( ) No
How many days per week? _____
( ) Beer ( )Wine ( ) Liquor
How many drinks at a time? _____

Transportation: ( ) Drive my own car ( ) Family / friends drive me ( ) Walk ( ) Bus ( ) Other

Other health questions or concerns:

COMPLETE THE NEXT PAGE IF YOU HAVE DIABETES

Diabetes Update

If you have diabetes, please complete this page before seeing your doctor.

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Have you been told by a doctor you have diabetes? ( ) Yes ( ) No If yes, when? _____
What type of diabetes do you have? ( ) Type 1 ( ) Type 2 ( ) Don't know

Please list all diabetes medicines you are taking.		

Do you feel your diabetes medicines are working properly? ( ) Yes ( ) No

What was your most recent A1c level? _____ ( ) Don't know

Circle any of these tools you have for managing your diabetes:	Medicine	Blood sugar monitoring machine / strips	Insulin
	Syringes		Lancets
	Family support	Friend support	Church support
	Understanding of diabetes	Blood sugar diary	An eating plan I enjoy

Would you like to learn more about managing your diabetes? ( ) Yes ( ) No

In the past 12 months, have you seen or been to:	Number of Visits	Reason
Primary doctor		
Emergency room		
Overnight hospital stays		
Eye doctor		
Foot doctor		
Diabetes education class or counseling		

What was your most recent fasting blood sugar at home? _____ ( ) Don't know

When do you check your blood sugar? Circle ***all*** the ones that apply to you.	I do not check it	Before meals
	Before an insulin shot	Whenever I think about it
	At bedtime	Twice a day
	Other _____	

Do you have strips to check your blood sugar? ( ) Yes ( ) No
Would you like to learn more about checking your blood sugar? ( ) Yes ( ) No

When your blood sugar is low, what do you do?			
What health concerns would you like to discuss today?	( ) Diabetes	( ) Weight	( ) Cholesterol
	( ) Blood pressure	( ) Eyes	( ) Kidneys
	( ) Tingly feet / hands	( ) Depression	( ) Sexual problem
	( ) Frequent infection	( ) Foot problem	( ) Stomach problem

Circle your eating plan.	No eating plan	Count carbohydrates
	"See food" plan (I eat the food I see!) ☺	I would like to learn about eating better
	Drink lots of fluids	Other _____
What is the hardest thing about having diabetes?		

LETTER OF SUPPORT

REQUIRED IF APPLICANT HAS NO INCOME, MUST BE NOTARIZED

APPLICANT

APPLICANT NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

APPLICANT SIGNATURE: _____ DATE: _____

PERSON PROVIDING SUPPORT (*CANNOT BE APPLICANT*)

NAME OF SUPPORTER OF ABOVE APPLICANT: _____

My signature below indicates that I provide or assist with food, lodging, transportation, and/or financial support for the above applicant.

SUPPORTER SIGNATURE: _____DATE: _____

NOTARY PUBLIC

The State of Alabama}.

County of _____}.

I, _____ *(NAME OF NOTARY PUBLIC)*, hereby certify that _____ (*NAME OF SUPPORTER*) whose name is signed to the foregoing conveyance, and who is known to me, acknowledged before me on this day that, being informed of the contents of the conveyance, he/she executed the same voluntarily on the day that bears the same date.

Given under my hand this _____day of _____, 20___

SEAL or STAMP BELOW

_____

(Notary Public in and for said County in said State)

Form **4506-T**
(March 2021)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

► **Do not sign this form unless all applicable lines have been completed.**
► **Request may be rejected if the form is incomplete or illegible.**
► **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ► _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

/ /	/ /	/ /	/ /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

► _____ _____
Signature (see instructions) Date

► _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

► _____ _____
Spouse's signature Date