



FIRST CAPITAL FUNDING CORPORATION

MONEY WHEN YOU NEED IT MOST

MEDICAL RECEIVABLE FINANCING APPLICATION

(WHEN COMPLETED FAX TO 888-755-8521)

Provider Legal Name: _____

Fictitious Names or dba's: _____

Provider Contact: _____

Type of Facility: Physician Hospital SNF Long Term Care DME Other

License Number: _____ Tax ID Number: _____

Medicare Number: _____

Address: _____

County in Which Facility is Located: _____

Telephone: _____ Fax: _____

Administrator/Owner: _____

Chief Financial Officer: _____

Manager of Collections: _____

Other: _____

What liens exist against the accounts receivable?

Bank: Yes No Amount if yes \$ _____

IRS: Yes No Amount if yes \$ _____

Other: Yes No Amount if yes \$_____

Why does the Provider seek receivables funding?_____

How long does the Provider seek receivables funding? _____

How much cash is requested at initial funding? \$_____

Is there current or pending litigation against the Provider? Yes No

If Yes, With Whom? _____

For what amount? \$_____

Does Provider do its own payroll? Yes No If Yes Third Party (Who)_____

Are payroll taxes current? Yes No If not, amount delinquent: \$_____

Are Federal taxes current? Yes No If not, amount delinquent: \$_____

Are State taxes current? Yes No If not, amount delinquent: \$_____

Has Provider ever had a Medicare or Medicaid offset? Yes No

If yes, amount of Offset \$_____

Amount of previous offset(s) remaining unpaid: \$_____

Is there a Medicare offset pending? Estimated amount: \$_____

Date of last Cost Report filing: _____

What is the average number of insurance claims billed per month?

Inpatient: _____ Outpatient: _____

What is the average dollar amount per claim billed?

Inpatient: _____ Outpatient: _____

Accounts Receivable Breakdown

Insurance _____% HMO/PPO _____% Medicare _____% Self pay _____%

Medicaid _____% Workers Comp _____% Other pay (Specify _____%)

Please complete the following breakdown:

Payor Type	Average Monthly Gross Charges	X	Net Collectable Percentage	=	Average Monthly Net Payment	Average Days to Pay
Commercial Insurance	\$	X	%	=	\$	
Medicare	\$	X	%	=	\$	
Medicaid	\$	X	%	=	\$	
HMO/PPO	\$	X	%	=	\$	
Workers Comp	\$	X	%	=	\$	

Total: \$ _____ Gross Billings \$ _____ Net Payments

What is the total amount of unpaid insurance claims aged less than 91 days in the above financial classes? \$ _____

Please include the following items with your application:

- An overview of the company and a description of its management team.
- Outstanding Debt of the assets it is encumbering, if any.
- The last two years financial statement.
- The most recent interim statement.
- Pro forma income statement for the current year or an estimate for growth in A/R
- A description of how much cash you need and the proposed use of the additional cash.
- A current aged trial balance of your accounts receivable in 30 day increments broken out by payor type (Medicare/Medicaid, commercial insurance, etc.) depicted in the form below:

	Days Outstanding						
	0-30	31-60	61-90	91-120	121-150	151-180	180+
Medicare							
Medicaid							
Blue Cross/Blue Shield							
Commercial Insurance							
HMO/PPO							
Self Pay							
Workers Comp							
Other							

Please Fax this application to 888-755-8521 or email to info@fcfcorp.com with summary aged trial balance report

Submitted By: _____ Date: _____

Reviewed By: _____ Date: _____