



## APPLICATION COVER SHEET and CHECKLIST

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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Referral Agent's Name: \_\_\_\_\_

Phone#: \_\_\_\_\_ Email \_\_\_\_\_

Who originated this transaction? \_\_\_\_\_

To what other lenders has this application been submitted? \_\_\_\_\_

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## CHECKLIST for MEDICAL INVOICE FACTORING

This checklist should be the first page of the application packet. Please package your client's application in the following order below; then fax to 888-547-7993 or email to [info@smartfinanceoptions.com](mailto:info@smartfinanceoptions.com).

- Application
- Latest two years financial statements (Audited or CPA provided)
- Most recent Interim Financial Statement
- Corporate Tax returns – Last two years
- An overview of the company and a description of the management team
- Desired amount of financing and proposed use of proceeds
- Outstanding debt and the assets it is encumbering
- A current aged trial balance of your Accounts Receivable (See page two of application)
- Additional documentation may be requested to strengthen the application, and answer any questions for the Underwriter.

# ACCOUNTS RECEIVABLE FINANCING PRELIMINARY APPLICATION

## *SMART FINANCE OPTIONS, INC.*

201 W. Stassney - #104-B - Austin, TX 78745

Telephone: 512-807-8159 - Facsimile: 888-547-7993

**Provider's Name:** \_\_\_\_\_

**Type of Practice / Business:** \_\_\_\_\_

**A/R Breakdown:**     **Insurance:** \_\_\_\_\_ %     **HMO/PPO:** \_\_\_\_\_ %

**Medicare:** \_\_\_\_\_ %     **Workers Comp:** \_\_\_\_\_ %

**Medicaid:** \_\_\_\_\_ %     **Self Pay:** \_\_\_\_\_ %

**Other (Specify):** \_\_\_\_\_ %

**Average Invoice Size:** \$ \_\_\_\_\_

(Invoice size is defined as the total dollar amount billed for a patient on a single HCFA Form or during an electronic transmission at one time)

**Average Time to Collect (in days):** \_\_\_\_\_

**Average Monthly Billing Volume:** \$ \_\_\_\_\_

**Average Monthly Collections:** \$ \_\_\_\_\_

**Average Monthly Operating Expenses:** \$ \_\_\_\_\_

**Reason for Attaining Working Capital / Use of Proceeds:**

\_\_\_\_\_  
\_\_\_\_\_

**Required Payoffs:**

1. \_\_\_\_\_

Party

Amount

Lien Filed (yes/no)



Legal Name of Entity: \_\_\_\_\_

Address of Central Office: \_\_\_\_\_

Name of Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

Address of all locations and other names used, if applicable: \_\_\_\_\_

Tax ID #'s: \_\_\_\_\_

Details of Business and Ownership Structure: \_\_\_\_\_

**FINANCIAL AND OPERATIONAL DATA:**

1. The latest two years of financial statements (audited, if available), most recent interim financial statement, and the latest two years of corporate tax returns.

2. An overview of the company and a description of its management team.

3. Desired amount of financing and proposed use of proceeds: \_\_\_\_\_

4. Outstanding debt and the asset(s) it is encumbering, if any: \_\_\_\_\_

5. A current Aged Trial Balance of your Accounts Receivable in 30-day increments broken out by payor type (i.e. Medicaid, Medicare, Commercial Insurance, etc.), in the form as follows:

Payor Class	Days Outstanding						
	0-30	31-60	61-90	91-120	121-150	151-180	180+
Medicare							
Medicaid							
Blue Cross/Shield							
Commercial Ins.							
HMO/PPO							
Self-Pay							
Workers Comp.							
Other (Specify)							

Once completed, please email to [info@smartfinanceoptions.com](mailto:info@smartfinanceoptions.com)

Or fax to: (888) 547-7993

Originating Agent: \_\_\_\_\_