GPA CAPITAL
Grice, Pope and Associates
Commercial and Healthcare Finance

MEDICAL ACCOUNTS RECEIVABLE FACTORING APPLICATION

BUSINESS INFORMATION

Legal Name of entity on Articles of Incorporation ____

Trade Names (DBA's) if applicable ____

Federal Tax ID # ____________________ Medicare Provider # _______________ NPI __________________________

If more than one legal entity: Name ____Tax ID________________

Name ____Tax ID________________

Address _______________________________________City _________________________ State ______Zip ________

Previous address if current less than three (3) years: ____

Primary Contact _________________________________ Email____

Phone (____) _____- ____ Fax (____) _____- ____ Website ____

Company is a Corporation _____ Partnership _____ Sole Proprietorship _____ LLC _____ Other ____________________

Date Business Started ____/ ____ / ____ State of Incorporation / Registration __________________________________

Has the name of the company changed within the last two years? ____NO ____YES *(If "yes" please provide previous name)* ____

Has ownership changed within the last two years? ____NO ____YES *(If "yes" please provide details)* _______________
____

Describe Type of Business ____
____

How many employees do you have? ______Do you have multiple offices? ______NO ______YES *(If "yes" please provide locations)* ____
____

LEGAL ENVIRONMENT

Has the Company or its Principal(s) ever been arrested or convicted of a felony? ___ No ___ Yes

Does the Company or its Principal(s) have any judgments or lawsuits filed against them? ___ No ___ Yes

Has the Company or its Principal(s) ever filed for bankruptcy? ___ No ___ Yes

Are there any Security Interest granted (UCC's Filed) against the Company or its Principal(s)? ___ No ___ Yes

Do you have outstanding/unpaid Payroll, Federal or State Income Taxes Liabilities? ___ No ___ Yes

Do you have any Installment Agreements for Payroll, Federal or State Income Taxes? ___ No ___ Yes

If YES to any answer above, please provide details ____
____
____

GPA Capital
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OWNERSHIP DISCLOSURE (If there are additional principals, provide details on a separate sheet of paper)

Officer Name/Title ____ Social Security # ________________

Home Address _____________________________________Home Phone (____) _____- ____ Ownership _______%

Medical Provider License # ___________________________ State of Issue _______ Date Issued ________________

Has this person ever owned or been part owner in another company? If so, please furnish the complete legal name, address, and any DBA´s of that company: ____

____

Officer Name/Title ____ Social Security # ________________

Home Address _____________________________________Home Phone (____) _____- ____ Ownership _______%

Medical Provider License # ___________________________ State of Issue _______ Date Issued ________________

Has this person ever owned or been part owner in another company? If so, please furnish the complete legal name, address, and any DBA´s of that company: ____

____

Officer Name/Title ____ Social Security # ________________

Home Address _____________________________________Home Phone (____) _____- ____ Ownership _______%

Medical Provider License # ___________________________ State of Issue _______ Date Issued ________________

Has this person ever owned or been part owner in another company? If so, please furnish the complete legal name, address, and any DBA´s of that company: ____

____

BASIC PROCEDURES INFORMATION

Have you, within the last two years, received correspondence and reports from audits, reviews, surveys, or inquiries by Medicare, the Fiscal Intermediary, State Department of Health, Social Services, Frauds Control Unit, or any other State or Federal agency or third party payor? ______NO ______YES *(If "yes" please provide details)* ________________________

____

____

Who is your billing company? ____

Contact Person at the billing company ____Phone (___) ___- ___

If internal, what software are you using for billing/AR? ____

Is your company presently capable of transmitting billing information electronically? _________ NO _________ YES

Is your monthly billing administration: _______Internally processed _______Outsourced

Are your collection procedures: ____________Internally administered _____Outsourced

<u>Bank Account(s):</u> (If more space is needed, please provide details on a separate sheet of paper)

Bank Name __________________________ Address ____

ABA ______________________________Account # ____

Bank Name __________________________ Address ____

ABA ______________________________Account # ____

Bank Name __________________________ Address ____

ABA ______________________________Account # ____

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Malpractice Insurance Carrier:

Name _________________________ Address ___________________________________

Contact Name ___________________ Phone (___) ____- ___ Email ________________________

Policy # ________________________________ Effective Date ____________________________

ACCOUNTS RECEIVABLE INFORMATION

What is your average monthly gross billing volume $ ____________________ Average net collectible percent _______%

Amount of open receivables (Total outstanding in GROSS Amount): $_____________________________________

Aging of receivables (GROSS Amount):
0-30 days: $_____________________________________
31-60 days: $_____________________________________
61-90 days: $_____________________________________
Over 90 days: $_____________________________________

How much of your average monthly billing do you intend to factor each month? $ _______________________________

Has the company or its principals currently or previously factored their receivables? _____ No ______ Yes, If YES, with whom? ____

Do you have any outstanding business/ practice loans? ______ No ______ Yes, *Balance owed* $ _____________________

Name of Financial Institution: ____

Contact Information ____

Specific reason why you are applying for this accounts receivable finance facility ________________________________

How did you hear about us? ____

The foregoing information is true and correct to the best of my knowledge and is given to Grice, Pope and Associates dba GPA Capital, (GPA) its affiliates, funding partners, third party underwriters and investors to induce GPA to consider entering into a factoring agreement with this company or provider. I/we do hereby authorize GPA, its affiliates, funding partners, third party underwriters and investors the right to verify and investigate any and all of the foregoing statements, including, but not limited to, my/our credit worthiness and financial responsibility, in any way it may choose. I/we grant GPA, its affiliates, funding partners, third party underwriters and investors the right to procure any and all reports including but not limited to credit reports and background investigations pertaining to applicant and any party listed in this application, including but not limited to, all principals of the applicant company. I/we grant GPA, its affiliates, funding partners, third party underwriters and investors the right to procure any and all reports pertaining to the above Medical Malpractice Insurance.

After review of your application, GPA will determine which of its affiliates will be best suited to meet your financing needs, and by signing below you consent to GPA sharing this application and the supplied information with its affiliates. By signing below, you consent to CFP or one or more of its affiliates to file a UCC-1 financing statement against the undersigned describing the collateral secured as “All assets of the Debtor, now existing and hereafter arising, wherever located”, or other “all asset” collateral description.

Agreed and Consented to by:

Signature________________________________ Title ________________________________

Print Name ________________________________ Date ________________________________

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