

FIRST CAPITAL FINANCIAL GROUP, LLC

Our process consists of three phases. First we will require you to complete this application and provide us with a basic set of documents listed below. Second, if your organization meets our initial underwriting qualifications, we will send you a Term Sheet with all the terms and conditions of a proposed transaction. It must be sent back signed, along with the second set of documents listed on the Term Sheet. Third, upon review of the remaining documents and our determination of a) the Net Collectible Value of your claims and b) the systems and controls established and used by your organization, your final eligibility will be determined.

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 _____ Website _____

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 _____

OWNERSHIP DISCLOSURE

Officer Name/Title _____ Social Security # _____ Ownership ____%
 Home Address _____ Home Phone (____) ____ - ____ Mobile Phone (____) ____ - ____
 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 # _____ Ownership ____%
 Home Address _____ Home Phone (____) ____ - ____ Mobile Phone (____) ____ - ____
 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 # _____ Ownership ____%
 Home Address _____ Home Phone (____) ____ - ____ Mobile Phone (____) ____ - ____
 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: _____

If there are additional principals, provide details on a separate sheet of paper.

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

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:\$ _____ 61-90:\$ _____ 91-120:\$ _____ Over 120:\$ _____

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 FIRST CAPITAL FINANCIAL GROUP LLC and its affiliates, agents and/or assigns to induce them to consider entering into a factoring agreement with this company or provider. I/we do hereby authorize First Capital Financial Group LLC ("First Capital") and its affiliates, agents and/or assigns 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 First Capital and its affiliates, agents and/or assigns 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 First Capital and its affiliates, agents and/or assigns the right to procure any and all reports pertaining to the above Medical Malpractice Insurance. After review of your application, First Capital will determine which of its affiliates, agents and/or assigns will be best suited to meet your financing needs, and by signing below you consent to First Capital sharing this application and the supplied information with its affiliates, agents and/or assigns. By signing below, you consent to First Capital or one or more of its affiliates, agents and/or assigns 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 _____

SUPPORTING DOCUMENTATION REQUIRED

- ✓ **Articles of Incorporation or Origination**
- ✓ **Driver's License from all owners (Scanned Legibly Please)**
- ✓ **Current Accounts Receivable Aging Summarized by Payor**

✓ **Please send your completed documentation to:**
First Capital Financial Group, LLC
Fax: (800) 497-7701
Email: underwriting@firstcapitalcommercialfinance.com
6565 N MacArthur Blvd, Ste. 225, #1030 Irving, TX 75039