Application for Financial Assistance for Facility Charges

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Patient Name (Last, First, MI) Social Security Number

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Patient Address City State Zip code

____ Marital Status: □ Married □ Single

Birth Date (Month/ Date/Year) Telephone □ Widowed □ Separated □ Divorced

Spouses Name ____________________________________

Employed □ Yes □ No Employed □ Yes □ No

Patient's Spouse's

Employer ______________________________ Employer _______________________________

Telephone # ____________________________ Telephone # _____________________________

A. Income: Please provide the income for each of the following persons in your household.

Patient □ Full Time □ Part time

$________ □ Hour □Week □ Bi-Week □Month □ Year

Spouse □ Full Time □ Part time

$________ □ Hour □Week □ Bi-Weekly □Month □ Year

Total Income $_____________

Please complete if patient is a minor (if not leave blank)

Father □ Full Time □ Part time

$________ □ Hour □Week □ Bi-Week □Month □ Year

Mother □ Full Time □ Part time

$________ □ Hour □Week □ Bi-Weekly □Month □ Year

Total Income $_____________

B. Income Verification: Please provide verification (send only copies, no original documentation) for all sources of household income (acceptable documentation listed below). Check attached documents:

□ Paycheck Remittance □ Employer Verification □ Government Assistance (food stamps, Medicaid, CDIC)

□ IRS form (W-2) □ Tax return □ Social Security, Workers Compensation, or Unemployment

□ Bank Statements □ Other (describe below)

If you are unable to provide one of the sources mentioned above, please explain why the information is unavailable:

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C. Family Members: Please provide the total number of people in the patient's household. (This number should include the patient, patient's spouse, patient's dependents, patient's parents- where applicable)

D. Assets and Other Resources:

Do you have any assets or other resources available to you? □ Yes □ No If Yes, current amount available: ___________
(examples include savings account, trust, stocks, bonds, etc.)

Do you have medical insurance? □ Yes □ No If Yes, please list provider:_________________

Do you have a Health Savings Account or □ Yes □ No If Yes, current amount available: ____________
or Flexible Spending Account?

I understand Piedmont Outpatient Surgery Center (POSC) may verify any information given in this Application for Financial Assistance. By my signature I hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize POSC to request reports from the Social Security Administration or Government Assistance programs. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are in good faith. I am aware that falsification of or misrepresentation of information on this Application may result in denial of financial assistance.

_______________________________________ _______________________________________ __________
Signature of Patient or Responsible Party Printed Name Date

For Facility Use Only

Notes Regarding Income Verification:

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