

## PATIENT FINANCIAL HARDSHIP APPLICATION

Upper Bay Surgery Center, LLC abides by the contractual and legal obligations of health benefit plans to collect charges, co-pay, co-insurance, and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, Upper Bay Surgery Center, LLC has adopted a policy of screening requests for discounts, delayed payment plans, or forgiveness of debt based on individual circumstances. In order to do this, we must ask for certain financial information. Please complete the following form to the best of your ability and provide the following supporting documentation:

- A copy of last year's tax return;
- Information from two recent payroll or unemployment benefit payments;
- If income is close to or below poverty level, denial of state medical assistance

All information will be held confidential as per Upper Bay Surgery Center, LLC's privacy policy.

Patient Name: Guarantor name(s):	DOB:	
Number of dependants per guarantor house Phone:	sehold: Number E-mail:	in school:
Type of Assistance Requested:		
Reduced deductible	Reduced co-pay/co-insurance	
Discounted cash services	l cash services Payment plan	
Employment/Unemployment Informat	ion (for each adult family r	nember):
Employer name:		
Address:		
Phone:		
If unemployed, please state when employ expected duration:	•	1 ·
Assistance Received:		
State financial assistanceWIC	Food Stamps	_ CHIP

## **Property/Investment Values:**

Home \_\_\_\_\_ Other real estate owned \_\_\_\_\_ Land \_\_\_\_\_

Business	Livestock	
Savings/stocks/bonds	Other Investments	

Notes:	

Please complete the information in the following table based on average income and expenses over the last twelve months. For amounts paid annually, enter annual amount divided by twelve.

Monthly Income	Monthly expenses (not including			
(after payroll deductions)	payroll deductions)			
Employment	Mortgage/rent			
Unemployment/severance	Auto/transportation			
Self-employment	Non-reimbursed work expenses			
	(e.g., parking, tools)			
Interest/dividends	Insurances (e.g., life, homeowners)			
Pension/disability	Utilities (lights, water, gas, trash)			
Child support/alimony	Medications			
Short-term disability	Childcare			
Long-term disability	Credit cards			
Rental income	Child support/alimony			
Other income:	Personal property taxes (home, auto)			
	Other:			
Total average income	Total average expenses			

## **Household Financial Information**

By my signature below, I certify that this information is true and complete. I grant Upper Bay Surgery Center, LLC permission to verify this information and acknowledge that completion of this form does not guarantee discount, payment plan, or forgiveness of debt.

You understand that incomplete and/or missing information will only delay in the approval process and the application will not be considered unless completed in full with all supporting documents within 30 days from the mail date.

Signed:	Date:	
*****	*******	*****
STAFF USE ONLY	DATE SENT:	INT:
• Reviewed by:	I	Date:
Approved for:		
• Next review date:		