Application for Financial Assistance

Patient Name: ____

Patient Address: ____

Phone #: ________________________ Date of Surgery: __________ _________________________

Email: ____

Total Charges: ____________________________________ Write Off Amount: __________________

Assistance Requested by: ____________________________ Relationship to Patient ________________

List every member of the patient's household, including patient, ***as listed on the tax return.*** *Use additional sheets if necessary.*

NAME	AGE	RELATIONSHIP	GROSS MONTHLY INCOME	SOURCE OF INCOME

PLEASE COMPLETE THE FOLLOWING SECTION ON YOUR ASSETS, LIABILITIES, INCOME AND EXPENSES:

Are you currently employed? Yes_____ No_______

Please provide a copy of two (2) most recent pay stubs and a copy of your current tax return.

Do you own or rent your home? ❑ Own ❑ Rent Monthly rent/mortgage amount: $ _______________________

Amount remaining on mortgage: $ ____

Do you own or lease your car? ❑ Own ❑ Lease Monthly car payment amount: $_________________

Remaining car loan balance: $ ____

How much is your monthly living expense? ❑ Less than $500 ❑Between $500 and $1,000 ❑Between $1,000 and $2,000 ❑ More than $2,000

Total family income for the last three (3) months $____

Checking Account Balance $ ______________________ Savings Account Balance $________________________

Non-Retirement Investment $ ___________________ Retirement Savings Balance $________________________

PLEASE CHECK IF YOU RECEIVE OR HAVE ANY OF THE FOLLOWING ADDITIONAL RESOURCES:

❑Commercial Insurance ❑Veteran's ❑ Champus/Tricare ❑ Medicare ❑Medicaid ❑SNAP ❑Food Stamps ❑TANF ❑COBRA ❑ Other, please specify: _____________________________________

Was this service due to an accident in which you may have a claim or be represented by an attorney? __________

If so, what is the attorney's name and contact information? ____

I certify that the above information is true and correct. I authorize Lake Ridge Surgery Center to verify this information with employers and other agencies. I also understand that this information is subject to review by Federal and/or State Agencies. I also understand that I am expected to make application to any other help, which may be available to me.

Signature: ____________________________________ Date: ________________________________

Place
Stamp
Here

Lake Ridge Surgery Center
ATTN: Business Office Manager
12825 Minnieville Road, Suite 204
Woodbridge, Virginia 22192

Dear Lake Ridge Surgery Center Patient,

As health care providers, we are concerned with the wellbeing of our patients from first entry to the Center through discharge and billing.

We understand that health care expenses are frequently unplanned and satisfying this financial obligation can seem overwhelming. This is especially true if you are not covered by health insurance.

If you think that you may be eligible for financial assistance or care at a reduced rate based on your income, please help us in evaluating your eligibility for assistance by completing this form and returning it to us.

You can also call us at (703) 357-9568. We look forward to assisting you.