Physicians Surgery Center of Frederick
FINANCIAL ASSISTANCE FORM

INSTRUCTIONS FOR COMPLETING THIS FORM

In order for a patient to be eligible for special financial consideration, this form should be completed and the requested documentation attached, and the form returned to **Physicians Surgery Center of Frederick.** The information will be verified and proper determination will be made in a timely manner. Please provide the following documentation to the facility:

- This form, completed and signed
- Copies of signed Federal Income Tax Return for previous year
- Copies of payroll check stubs for the previous 2 months
- Copies of recent utility bills, rent/mortgage receipt, medical bills, auto loan receipts, bank statements, alimony/child support receipts, government assistance receipts, other income/investment statements (e.g. 401K statement)

RESPONSIBLE PARTY INFORMATION

Responsible Party ______________________ Marital Status ______________________

Address ______________________ State ____________ Zip ____________

SSN ______________________ Birth Date ____________ Phone ____________

Employer ____________ Position ____________ Phone ____________ Hire Date ____________

Address ____________ City ____________ State ____________ Zip ____________

Spouse ______________________ Birth Date ____________ SSN ____________

Spouse's Employer ____________ Position ____________ Phone ____________ Hire Date ____________

Number of children in the house ____________ Ages ______________________

MONTHLY INCOME INFORMATION

Please provide documentation of income sources – W-2 forms, income tax statements, check stubs, or check statements. A financial statement may be required if you are self-employed.

	Responsible Party	Spouse
Wages before deductions		
Alimony/Child support		
Disability/worker's comp		
Pension		
Social Security Income		
Dividends/Interest Income		
Rental Income		
Estate Trust Income		
Welfare/Public assistance		
Food Stamps		
Other (please list)		
Less State/Federal Taxes		
Less any other deductions		
Monthly Income Total	$	$

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FINANCIAL INFORMATION

ASSETS	VALUE		VALUE
Cash/Checking	________	Investments	________
Savings	________	Life Insurance	________
Stocks and Bonds	________	Other	________

ALL REAL PROPERTY AND VEHICLES

		VALUE	BALANCE	MONTHLY PAYMENT
Residence rent / own (circle one)		________	________	________
Other property	________	________	________	________
Vehicle #1	Make Model	Year ________	________	________
Vehicle #2	Make Model	Year ________	________	________
Vehicle #3	Make Model	Year ________	________	________

MEDICAL EXPENSES

Medical Provider's Name	BALANCE	INS WILL PAY	MONTHLY PAYMENT
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________

LIST ALL OTHER CREDITORS

(Charge cards, mail order, etc. - - attach separate sheet if necessary)

CREDITOR'S NAME	TYPE LOAN	BALANCE	MONTHLY PAYMENT
________	________	________	________
________	________	________	________
________	________	________	________

Appliance or furniture rental: ________

Have you ever filed bankruptcy? Yes ________ No ________ Give date ________

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OTHER MONTHLY EXPENSES

EXPENSE	MONTHLY PAYMENT	EXPENSE	MONTHLY PAYMENT
Food	______________	Auto Insurance	______________
Phone	______________	Cable TV	______________
Electric/Gas/Water/Sewer	______________	Health Insurance	______________
Contributions	______________	Recreation	______________
Other (List)	______________	Other (List)	______________

FOR OFFICE USE ONLY…

MONTHLY FINANCIAL SUMMARY

Total Income: ______________________

Subtotals:

Real property Vehicles $______________

Monthly Medical Expenses $______________

Creditors Credit $______________

Other Monthly Expenses $______________

Total Expenses: ______________________

PATIENT CONDITIONS AND COMMENTS

Please answer the following questions – attach additional pages if necessary

Have you applied for Medicaid and been denied or found to be ineligible? Yes No (circle one)

Have you asked for assistance from your family? Yes No (circle one)

____

Have you asked for assistance from your clergy or church? Yes No (circle one)

____

How much are you able to pay each month? ______________

COMMENTS: ____

____

I hereby state that the information I have provided is true and complete. I authorize **Physicians Surgery Center of Frederick** to verify this information, including requesting a credit bureau report. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration and I will be liable for payment of any and all charges incurred for the services rendered.

X ______________________________ **Date:** ______________

Responsible Party Signature

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