CHARITY CARE DOCUMENTATION REQUIREMENTS

CHARITY CARE APPLICATION DOCUMENTATION

Horizon Surgery Center South may require some or all the following documentation based upon the individual Charity Care Application

Required Documentation

A. Charity Care Application and Patient Attestation Form

B. Proof of Income – from all sources, listing gross income for the most recent four-week period.

C. Copies of most recent Federal Income Tax Return.

D. Last two months on bank statements for savings accounts and checking accounts.

E. Cash balances as of the date of service from certificates of deposit, stocks, and bonds.

F. Number of dependents. Unborn children are not added to the family size. Death of a spouse or dependents will only be included in family size for the year of the death.

G. Insurance Cards for patient, spouse, and/or children.

H. Personal ID for patients, spouse, children under 18, and/or full-time college students 21 and under. Identity can be Driver's License, Passport, Social Security Card, or Birth Certificate.

Other Documentation at the Request of Horizon Surgery Center South

A. Assets including home, automobiles, boats, and real estate other than primary residences.

B. Monthly household expenses as well as loan payments.

C. Credit Bureau check accounts balance of $2,000 or more.

D. Board of Assessment – Property Value check (as required).

Horizon Surgery Center South

FINANCIAL EVALUATION FORM

Account Number:		MR Number:

Patient's Name: _____ Social Security Number: _____
Street Address: _____ Telephone #: _____
City: ST: _____ ZIP: _____

Please provide the following information completely and accurately. Information is subject to verification. ***Providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second (2nd) degree.***

List All household member names	Date of Birth	Social Security Number	Relationship to patient	Employer

Monthly Income		**Monthly Expenses**	
Responsible Party's Gross Salary	$	Rent/Mortgage/Housing	$
Spouse's Gross Salary	$	Electricity	$
Investment Income	$	Water/Sewage	$
Child Support/Alimony	$	Telephone	$
Rental Property Income	$	Groceries	$
Annuities/Stocks/Dividends	$	Transportation (automobile insurance)	$
Pension/Retirement/Unemployment	$	Medical Bills	$
Other:	$	Other:	$
Total Monthly Income	$	**Total Monthly Expenses**	$
Assets		**Liabilities**	
Value of Residence(s)	$	Residence Loan Balance/Mortgage	$
Checking Account	$	Balance Owed on Credit Cards	$
Savings/Money Market/CD's	$	Auto Loan	$
Value-Auto/Boat	$	Medical Bills (total outstanding)	$
Other:	$	Other:	$
Total Value of Assets	$	**Total Liabilities**	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in the denial of the application for any type of financial assistance. If I am entitled to any action against or settlement from third party payors, I will take any action necessary or requested by Horizon Surgery Center South to obtain such assistance and will assign to Horizon Surgery Center South, and upon receipt will pay to Horizon Surgery Center South, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions necessary or requested by Horizon Surgery Center South will result in the denial of this application. I also authorize Horizon Surgery Center South to check my credit history through the credit bureau, if deemed appropriate.

_____ _____
Signature of Patient (Responsible Party) Date

Horizon Surgery Center South
PATIENT ATTESTATION
SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION

1. I attest that as of _____(date) I have NOT received any income or filed any income tax returns.

_____ _____
Patient/Responsible Party Relationship Date

2. I attest that I have NO ASSESTS (Bank accounts, CD's, Etc.) through myself or any other party.

_____ _____
Patient/Responsible Party Relationship Date

3. I attest that I am HOMELESS and have been HOMELESS since _____
Date

_____ _____
Patient/Responsible Party Relationship Date

4. I attest that I have NO MEDICAL COVERAGE through myself or any other party to cover the outstanding amount of my bills.

_____ _____
Patient/Responsible Party Relationship Date

5. I attest that I am/was a Florida Resident at the time of services were received and I intend to remain a Florida Resident.

_____ _____
Patient/Responsible Party Relationship Date

6. I AFFIRM THAT ALL INFORMIATION GIVEN ON THIS ATTESTATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
Patient Responsible Party Relationship Date

_____ _____
Interviewer Date