EFFINGHAM UROLOGY ASSOCIATES

Patient Name _____ Date_____

Account Number_____ Balance_____

********** Request for Financial Aid Due To Economic Hardship

Governmental *(Medicare)* or contractual obligations (*commercial insurance)* require us to collect co-payment, deductible and co-insurance unless you can prove economic hardship. To do so you must provide our office with the following information. **Include a recent tax return and W-2 with this application for us to consider your request.**

YOUR FAMILY'S MONTHLY INCOME		YOUR ASSETS	
Work or Wages	$		
Disability	$	401k value	
Retirement	$	Retirement	
Social Security	$	House value	
Other Income	$	Property	
		Health Savings Account	
Total Income	$		

YOUR FAMILY'S MONTHLY EXPENSES		YOUR DEBTS	
House Payment or Rent	$		
Food	$	Loan 1	
Utilities - Electricity, Water & Gas	$	Loan 2	
Car Payment	$	Credit Card 1	
Gas, Repairs & Insurance for Car	$	Credit Card 2	
Prescriptions	$	Other	
Doctor Bills	$	Other	
Hospital Bills	$	Other	
Health Insurance	$		
Cable, Satellite, Cell Phone	$		
_____	$		
_____	$		
_____	$		
_____	$		
Total Expenses	$		

Do you have any dependents? Y___ N___ Names/Ages_____

Are you employed? Y____ N ____ Is your spouse/significant other employed? Y____ N ____

Do you own an RV or other recreational equipment? Y____ N____ If yes, what is the value? $_____

Amount you are requesting be waived? _____

I am unable to pay the un-reimbursed medical charges due to economic hardship. I hereby certify that the information I have provided is true and correct. If my income increases, I will notify my doctor.

Patient Signature _____

Date _____

Authorized Signature/Date_____