Obici Ambulatory Surgery Center
2750 Godwin Blvd.
Suffolk, VA 23434
Phone: 757-983-2000
Fax: 757-983-2001

Sentara Obici Ambulatory Surgery Center
Application for Financial Assistance for Ambulatory Surgery Charges

_____
Patient Name Patient Account Number

_____
Social Security Number Birth Date (Month/Day/Year) Telephone Number

_____
Patient Address City State Zip Code

_____
Employer Name (Name, Address and Telephone) (If unemployed, list previous employer information)

_____
Spouse Name (or Father and Mother if Patient is a Minor) Social Security Number

_____
Spouses Employer (Name, Address and Telephone) (If unemployed, list previous employer information)

A. Income: Please provide the income for each of the following persons in your household.

Circle One

Patient $ _____ Hr / Wk / Month / Year

Patient's Father $ _____ Hr / Wk / Month / Year
(If patient is a minor)

Patient's Mother $ _____ Hr / Wk / Month / Year
(If patient is a minor)

Spouse $ _____ Hr / Wk / Month / Year

Total (Combined) Income $ _____

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B. *Family Members:* Please provide the number of people in the patient's household. _____

C. *Income Verification:* Please provide as many of the following types of documentation to verify your income (listed in order of preference)

1) Paycheck Remittance
2) Bank Statements
3) Tax Return
4) Employer Verification
5) Social Security, Worker's Compensation, or Unemployment Compensation, Determination Letters
6) Proof of Participation in Governmental Assistance programs such as food stamps, CDIC, Medicaid or AFDC
7) IRS Form W-2
8) Other, Please Describe _____

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available

_____
_____
_____
_____
_____

D. Assets and Other Resources

Do you have any assets or other resources available to you? ☐ Yes ☐ No
If yes, Current amount available $ _____
(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)

Do you have medical insurance? ☐ Yes ☐ No
If Yes, please list provider name: _____

Do you have a Health Savings Account? ☐ Yes ☐ No
If Yes, Current Amount Available$ _____

Do you have any assets or other resources available to you? ☐ Yes ☐ No
If yes, please list: _____

Do you have a Medical Flexible Spending Account? ☐ Yes ☐ No
If Yes, Current Amount Available $ _____

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I further understand that the physicians providing services are not employees of Sentara Obici Ambulatory Surgery Center. I understand that I will receive separate bills from my private physician and from other physicians whose services I required and that any assistance granted by SOASC excludes those physician charges.

I understand Sentara Obici Ambulatory Surgery Center ("SOASC") may verify the financial information contained in this Financial Assistance Application in connection with SOASC's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize SOASC to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance.

_____ _____
Signature of Patient or Responsible Party Printed Name

_____
Date

_____ _____
SOASC Employee Signature. Printed Name

If any part of Financial Assistance Application Completed by a SOASC Employee

_____
Date

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For SOASC Use Only:

Income Verification:

Name of Person Contacted: _____

Date: _____

Information obtained:

_____

_____

SOASC employee signature: _____ Date: _____

Notes regarding number in household:

_____

_____

If patient / responsible party is unable to sign the application, state why:

_____

Other notes:

_____

_____