PRINCESS ANNE AMBULATORY SURGERY CENTER
1975 GLENN MITCHELL DR. STE 300
VIRGINIA BEACH, VA 23456
757-507-0170

Financial Assistance Application – Eligibility Determination

Patient Name:_____ MR#:_____

Patient Address:_____

Phone #:_____ Date of Service: _____

Total Charges:_____ Amount of Charity Requested: _____

Charity 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:	EMPLOYER ADDRESS & PHONE #:

Total number in household: _____ Do you own your home? [ ] Yes [ ] No or Do you rent? [ ] Yes [ ] No

Other Sources of Income	*Gross Amount per Month*
_____	_____
_____	_____

Last 3 Months Total Family Income: _____ X 4 = 12 Months Total _____ Total Gross Income

CHECK ANY OF THE FOLLOWING MEDICAL RESOURCES THAT YOU HAVE:

[ ] Commercial Insurance [ ] Veteran's Affair [ ] Tricare [ ] Medicare [ ] Medicaid

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

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

In order for your application to be complete, YOU MUST INCLUDE THE FOLLOWING INFORMATION:
The last two (2) years of your Federal Income Tax return (W2's alone are not sufficient).

I certify that the above information is true and correct. I authorize Princess Anne Ambulatory 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 Requested:* _____

To be completed by PAASC: Date received: _____ *Documents for income verification:* _____

[ ] Approved for Charity [ ] Reduced Fee [ ] Denied Reason: _____

*Approved By:*_____ *Date:* _____