COMPLETED BY ANDREWS INSTITUTE STAFF ONLY	
Patient Name	
Patient Date Of Birth	
Guarantor Name	
Account Number	
Date Of Service	
Account Balance	

Dear _____:

As we discussed on the date of [ ], please find the attached checklist and application for our Financial Assistance Program.

Please review the checklist along with the detailed instructions and provide the documents required in order to be considered eligible for any financial assistance. The application must be completed, signed and dated, and sent back to our office within 10 days from receipt, unless medical services are identified as emergent; then application must be returned within 48 hours.

Any applications received that are not signed or missing any of the required information will not be considered. All information obtained relating to financial assistance is strictly for the sole purpose of determining eligibility for our Financial Assistance Program and will be kept completely confidential.

Your application will be reviewed by our Finance Department; you may be contacted for verification/clarification if necessary. Upon determination of approval or denial, you will be notified within 48 hours of the final decision. If approved, the discount will only apply to the balance identified above.

If you have any questions, please do not hesitate to contact our office, Monday through Friday, 5:30 a.m. to 4:30 p.m. at 850.916.8500.

Sincerely,

Andrews Institute Surgery Center

Enclosed: Financial Hardship Application Checklist
Financial Hardship Application

FINANCIAL STATEMENT
PAYMENT PLAN/ UNCOMPENSATED SERVICES APPLICATION

Please provide the following information (where applicable) so we can complete your application:

- Most recent IRS tax forms (prior year tax return and W-2) (must be signed)
- Check stubs for the past 60 days for all persons employed in the home. This includes (if applicable) copies of the most recent social security checks for Medicare recipients
- Unemployment check stubs for the past 30 days
- Driver's license or identification card for guarantor(s)
- Proof of all other income received in the past 60 days
- Proof of all monthly expenses (copy of most recent bank statement)
- Attached financial statement (completely filled out and signed)
- Proof of current outstanding medical obligations to any other entities

Please return all items on this checklist (in person or by mail) within ten (10) days of receipt unless otherwise stated by Andrews Institute Surgery Center staff due to urgency of the medical condition.

You will be notified upon approval of any payment plan terms and/or discount within two (2) business days from final decision of your application's approval.

Please be sure to sign the attached financial statement. Your request will not be processed if this is not signed.

FINANCIAL STATEMENT
PAYMENT PLAN/ UNCOMPENSATED SERVICES APPLICATION

TO BE COMPLETED BY PATIENT/GUARANTOR ONLY

PATIENT NAME:	DATES OF SERVICE:	
NAME OF RESPONSIBLE PARTY:		
RELATIONSHIP TO PATIENT:		
SPOUSE:	TELEPHONE:	CELL:
ADDRESS:		
NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD):		
EMPLOYER:	PHONE:	ADDRESS:
IF UNEMPLOYED, HOW LONG:		
INCLUDE MEMBER NAME, ADDRESS AND AGE:		
FAMILY MEMBER NAME:		
FAMILY MEMBER AGE:		
FAMILY MEMBER RELATION:		
FAMILY MEMBER NAME:		
FAMILY MEMBER AGE:		
FAMILY MEMBER RELATION:		
FAMILY MEMBER NAME:		
FAMILY MEMBER AGE:		
FAMILY MEMBER RELATION:		
FAMILY MEMBER NAME:		
FAMILY MEMBER AGE:		
FAMILY MEMBER RELATION:		

MONTHLY FAMILY INCOME AND SOURCE

	PATIENT	SPOUSE	RESPONSIBLE PARTY
MONTHLY SALARY (GROSS)			
PUBLIC ASSISTANCE			
UNEMPLOYMENT BENEFITS			
SOCIAL SECURITY BENEFITS			
WORKERS COMPENSATION			
CHILD SUPPORT			
OTHER (ALIMONY, ETC.)			

TOTAL FAMILY INCOME: $_____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE ANDREWS INSTITUTE SURGERY CENTER TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED, INCLUDING, BUT NOT LIMITED TO, OBTAINING A CREDIT REPORT.

_____

SIGNATURE OF PERSON MAKING REQUEST DATE DATE OF BIRTH

_____

SIGNATURE OF SPOUSE/OTHER FINANCIAL RESPONSIBILITY DATE DATE OF BIRTH

DO NOT WRITE BELOW THIS LINE- FOR OFFICE PERSONNEL USE ONLY

This document was received on _____ by_____.

(Date) (Name/Title)

Approved by Business Office Manager:_____