

## CAREPLEX ORTHOPAEDIC FINANCIAL ASSISTANCE APPLICATION

Patient Last Name	First		MI		
SS#	First Date of Birth1	Marital Status	Phone#	_	
Patient					
Address					
Employer	Spouse's	Employer			
Family Members (List spe	ouse and dependent children unde	r 18 years, or as liste	d on your taxes and their date(s)		
of birth):					
Name	Date of Birth	Name	Date of Birth		
1	/4. /5.		/		
2	/5.		//	_	
3	6.		/		
APPLICAN	ITS MUST SUBMIT ALL REQUIRED D		SAME MAILING TO:		
	COASC Financial Assi	•			
	3000 Coliseu	-			
	Hampton, Vo				
	lease answer <u>each</u> question and pro				
	URED PATIENTS MUST PARTICIPAT				
Please answer all question	ons listed below	-	provide the following for <u>EACH</u> r ceiving the benefit.	nember of the	
Is any member of your hous	sehold <b>self-employed? 🗅</b> YES 🗅 NO		( form(s) including business taxes fror test quarterly filing listing income for		
Is any member of your hous	sehold <b>employed</b> ? 🗅 YES 🗅 NO	3 most recent p	bay stubs or signed letter from emplo	yer	
Is any member of your hous	sehold receiving <b>unemployment benef</b> i	ts? Benefit letter o	r Unemployment printout from State	website	
Is any member of your hous NO	sehold receiving <b>Social Security</b> ?  YES	□ SS benefit lette	er or complete bank statement if direc	ct deposited	
Does any member of your h <b>Retirement</b> ?  YES  NO	ousehold receive a Pension or	Pension/Retire deposited	Pension/Retirement letter or complete bank statement if direct deposited		
Does any member of your h	ousehold receive <b>SNAP benefits</b> ?   YE	S SNAP Letter			
Does any member of your h	ousehold receive a Child Support?	ES Court ordered	document or letter from non-custodia	al parent	
Does any member of your h property? YES NO	ousehold own rental or investment	Rental agreem	ent/documentation listing income am	nount	
Does any member of your h	ousehold have other sources of Incom	e? Stocks, Bonds, statement(s)	CD's additional property, etc Attach	l current	
Does any member of your h or money market account ?	ousehold have a <b>checking, savings</b> ?	Attach complet	te copy of current 30 day statement fo	or each account	

#### NO INCOME: U YES U NO

If your household is claiming no income you must provide a notarized letter stating such.

#### >>>Continued<<<

# FINANCIAL ASSISTANCE APPLICATION

Patient Last Name		First	
	Personal Asset Valu	ie List	
Annual Household Income \$	Social Securit	zy \$	
Spousal Support \$	Government	Assistance \$	i
Monthly Rent/Mortgage \$	Othe	er Suppleme	ntal Income \$
Monthly Utilities \$			
Was treatment for this service due to a does not apply to treatment related to accidents or other treatment for which suffering and other damages).	work injuries, cosm	netic proced	ures or flat rate procedures,
Do you have health insurance 🗅 YES 🗅	NO (If YES, please p	rovide furth	er information below)
1. Insurance Name Poli			
2. Insurance Name Poli	cy Holder Name		Policy#
I hereby request that Careplex Orthopa assistance. I understand that, if the info determination may result in a denial of provided. I certify that the above inform knowledge. I acknowledge that coopera considered for financial assistance.	ormation which I sub my application and t nation is true, compl	mit is deterr that I may be lete, and cor	nined to be false, such e liable for charges for services rect to the best of my
Additional Comments			
Signature of Responsible Party:			Date:

Careplex Orthopaedic ASC, reserves the right to validate information reported in the Financial Assistance application, such efforts to validate personal income or lack thereof, will be conducted in such a manner as to maintain the utmost confidentiality and in no way generate any report by any credit bureau agency that could adversely affect the privacy of the applicant.

If you need additional assistance, please visit a financial counselor at 757-736-4103.

3000 Coliseum Drive, Hampton VA 23666

Monday - Friday 8:30 AM to 4:30pm

### CarePlex Orthopaedic Ambulatory Surgery Center Financial Assistance Policy for Patients Plain Language Summary

If you are uninsured or unable to pay your bill, please contact us at the number below to see if you are Eligible for financial assistance. Free care is available to any uninsured patient whose income is 250% or below the federal poverty level as published annually by the U.S. Department of Health and Human Services (see http://aspe.hhs.gov/poverty/index.cfm for the current guidelines.)

The complete financial assistance policy, along with an application for financial assistance, can be found at http://www.careplexortho.com Paper copies are also available at the patient registration area of the CarePlex Orthopaedic Ambulatory Surgery Center and will be mailed free-of-charge to a patient upon request:

Requests by phone: 757-736-4103 Requests by mail: CarePlex Orthopaedic Ambulatory Surgery Center Attn: Financial Assistance 3000 Coliseum Drive Hampton, VA 23666

Patients may also call or visit the above location to receive assistance with the application process. Patients eligible under the financial assistance policy will not be charged more than amounts generally billed to individuals who have insurance covering such care.