

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.		/			
APPLICANTS MUST SUBMIT ALL REQUIRED DOCUMENTS IN THE SAME MAILING TO:						
	COASC Financial Assi	•				
3000 Coliseum Drive						
	Hampton, Vo					
Please answer <u>each</u> question and provide the information requested UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY						
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 self-employed? 🗅 YES 🗅 NO		(form(s) including business taxes fror test quarterly filing listing income for			
Is any member of your hous	sehold employed ? 🗅 YES 🗅 NO	3 most recent p	bay stubs or signed letter from emplo	yer		
Is any member of your hous	sehold receiving unemployment benef i	ts? Benefit letter o	r Unemployment printout from State	website		
Is any member of your hous NO	sehold receiving Social Security ? YES	□ SS benefit lette	er or complete bank statement if direc	ct deposited		
Does any member of your h Retirement ? 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 SNAP benefits ? 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 checking, savings ?	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	
F	Personal Asset Value	e List	
Annual Household Income \$	Social Security	\$	
Spousal Support \$	Government A	ssistance \$	
Monthly Rent/Mortgage \$	Other	Supplemer	ntal Income \$
Monthly Utilities \$			
Was treatment for this service due to an does not apply to treatment related to vaccidents or other treatment for which suffering and other damages).	work injuries, cosme	etic procedu	ures or flat rate procedures,
Do you have health insurance 🗅 YES 🗅 N	NO (If YES, please pro	ovide furthe	r information below)
1. Insurance Name Policy			
2. Insurance Name Policy	/ Holder Name		Policy#
I hereby request that Careplex Orthopae assistance. I understand that, if the infor determination may result in a denial of n provided. I certify that the above informa knowledge. I acknowledge that cooperat considered for financial assistance.	mation which I subn ny application and th ation is true, comple	nit is determ nat I may be ete, and corr	nined to be false, such 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.