Charity Care and Financial Assistance Program Application

Section 1: Patient Information

NAME	MEDICAL RECORD NUMBER (OPTIONAL)
DATE OF BIRTH	SOCIAL SECURITY NUMBER (OPTIONAL) ☐ I do not have a Social Security Number
MAILING ADDRESS (STREET)	
CITY	STATE / ZIP CODE
Is patient currently unhoused? ☐ Yes ☐ No	PRIMARY PHONE NUMBER ☐ Home ☐ Mobile ☐ Work ☐ Other

Is the patient enrolled in a state-based assistance program such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants & Children (WIC), low-income housing, or Medicaid? ☐ Yes ☐ No

Section 2: Household Information

Household size: Number of household members (including you) who live in your home. May include a spouse or qualified domestic partner, children, a non-parent caretaker, relative, etc. _____

Household income (monthly): Total gross income (income before taxes and deductions) for all household members over 18 years of age. Check ALL income types that apply:

- ☐ Business/rental income.
- ☐ Employment income/wages.
- ☐ Veterans' benefits income.
- ☐ Interest or dividends income
- ☐ Self-employed income.
- ☐ Social Security/supplemental security
- ☐ Unemployment benefits/disability income
- ☐ Spousal/child support payments received
- ☐ Received pension/retirement/annuities

☐ No one in my household is earning or has received invome in the last 2 months

If the annual gross income for all household members is zero, check the attestation box above. Below, provide a written explanation as to how the adult family members in the household support yourselves without income, i.e., food, shelter, utilities, and other necessities.

$ _____

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Health care costs: Total out-of-pocket expenses you had over a 12-month period for emergency, or medically necessary services provided by any other health care provider. May include copays, deposits, coinsurance, or deductible payments for eligible medical, pharmacy, or dental services.	$_____

I hereby declare that all information set forth above in this application is true, accurate, and complete in all respects. I also acknowledge and agree that I am liable to Harborside Surgery Center owing for medical goods and services that are not eligible under the program (the "Remaining Amounts").

By submitting this application, I provide Harborside Surgery Center permission to request information from consumer credit reporting agencies and other third-party information sources to verify any information provided in this application that is deemed necessary.

SIGNATURE	DATE