



PATIENT FINANCIAL HARDSHIP APPLICATION

Upper Bay Surgery Center, LLC abides by the contractual and legal obligations of health benefit plans to collect charges, co-pay, co-insurance, and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, Upper Bay Surgery Center, LLC has adopted a policy of screening requests for discounts, delayed payment plans, or forgiveness of debt based on individual circumstances. In order to do this, we must ask for certain financial information. Please complete the following form to the best of your ability and provide the following supporting documentation:

- A copy of last year's tax return;
- Information from two recent payroll or unemployment benefit payments;
- **If income is close to or below poverty level, denial of state medical assistance**

All information will be held confidential as per Upper Bay Surgery Center, LLC's privacy policy.

Patient Name: _____ DOB: _____
Guarantor name(s): _____
Number of dependants per guarantor household: _____ Number in school: _____
Phone: _____ E-mail: _____

Type of Assistance Requested:

Reduced deductible _____ Reduced co-pay/co-insurance _____
Discounted cash services _____ Payment plan _____

Employment/Unemployment Information (for each adult family member):

Employer name: _____
Address: _____
Phone: _____
If unemployed, please state when employment terminated or if lay-off is temporary, indicate expected duration: _____

Assistance Received:

State financial assistance _____ WIC _____ Food Stamps _____ CHIP _____

Property/Investment Values:

Home _____ Other real estate owned _____ Land _____

