PEACHTREE ORTHOPEDIC SURGERY CENTER at PIEDMONT, LLC
PEACHTREE ORTHOPEDIC SURGERY CENTER at PERIMETER, LLC
PEACHTREE ORTHOPEDIC SURGERY CENTER North, LLC

FINANCIAL ASSISTANCE APPLICATION

Peachtree Orthopedic Surgery Center at Piedmont, LLC ("POSC"), Peachtree Orthopedic Surgery Center at Perimeter, LLC ("POSCP"), and Peachtree Orthopaedic Surgery Center North ("POSCN") are committed to providing quality ambulatory outpatient care to all individuals regardless of their financial status. If you are uninsured, underinsured, or have substantial outstanding medical expenses and inadequate resources to pay for your surgical procedure, you may be eligible for free or discounted care through the Surgery Center's Financial Assistance Program. This program is **only applicable to the Surgery Center locations** listed above. **Billable provider charges outside of surgery center fees will be due on or before services are rendered unless arrangements have been made beforehand.**

To apply for Financial Assistance, please complete this application **and** return with proof of income document(s). All asterisk (*) items are required. Unless additional information is requested, we will generally notify you within five (5) business days as to whether you qualify for free or discounted care.

SECTION I. DEMOGRAPHIC INFORMATION

Patient Name:	
Patient DOB:	
E-mail address (OPTIONAL for contact purposes only)**:**	
Responsible Party Name ***(if not patient)*****:**	
Responsible Party Address	
Responsible Party Phone:	
Home:	
Cell:	
Work(optional):	
Employers Name:	
Number of members in your household:	
Gross Income:	
Per Month:	$
Per Year	$

** ***Gross Income includes the total household income for the previous twelve (12) months, including, without limitation, all earnings/wages, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, pension or retirement income, alimony and child support.***

SECTION II. FINANCIAL INFORMATION

Please indicate below, your family household size and whether your family's Gross Income for the last year (last 12 months), is above or below the Gross Income figures given for your family.

Household Size (circle one)	125% Income Level		Check One		300% Income Level		Check One	
	Per Year	Per Month	Above	Below	Per Year	Per Month	Above	Below
1	$13,590	$1133	☐	☐	$30,216	$2,518	☐	☐
2	$18,310	$1,526	☐	☐	$43,944	$3,662	☐	☐
3	$23,030	$1,919	☐	☐	$55,272	$4,606	☐	☐
4	$27,750	$2,313	☐	☐	$66,600	$5,550	☐	☐
5	$32,470	$2,706	☐	☐	$77,928	$6,494	☐	☐
6	$37,190	$3,099	☐	☐	$89,256	$7,438	☐	☐

7	$41,910	$3,493	☐	☐	$100,584	$8,382	☐	☐
8	$46,630	$3,886	☐	☐	$111,912	$9,326	☐	☐
9	$51,350	$4,279	☐	☐	$123,240	$10,270	☐	☐
10	$56,070	$4,673	☐	☐	$134,568	$11,214	☐	☐

SECTION III. MEDICAL OR OTHER HARDSHIP

If you currently have outstanding medical bills or other financial hardship that will hinder your ability to reimburse POSC for your surgical procedure, please complete the following section. Additionally, please ensure that you have completed Sections 1 and 2 above. If this section does not apply to you, you may skip to Section 4.

I currently have outstanding medical bills and expenses in the amount of $_____.

I am currently able to make minimal monthly payments on these medical bills and expenses.

☐ YES

☐ NO

I am currently paying off these medical bills and expenses in the amount of $_____ per month.

Based on the other unusual circumstances (detailed below), I am facing financial hardship that would impede my ability to obtain the surgical procedure without financial assistance:

____
____
____
____
____

If you completed Section 3, please enclose, along with this application, evidence of your outstanding medical bills and related expenses or other evidence of unusual financial hardship.

SECTION IV. ADDITIONAL INFORMATION

All applications will be evaluated on an individual basis and if there is any additional information you believe will help in determining whether you are eligible for financial assistance, please enclose that information (e.g., proof of gross income and expenses such as W-2 forms, tax returns, unemployment forms, bank statements, written verification of wages from employer, verification of pension or retirement income, monthly expenses). Please note that additional supporting information or documentation may be requested by to evaluate your application for financial assistance.

POSC will treat all information included in this application and any additional information provided as confidential and will only use this information for purpose of evaluating your request for financial assistance. Please be aware any assistance offered for your upcoming procedure is only applicable for the Surgery Center charges. It will not be applied to any other provider services incurred during or after the facility visit.

Until final receipt of the completed application and supporting income records are received and fully reviewed with a status, your surgical or pain management procedure is still your responsibility for upfront payment. This application does not prevent collection of your expected deposits until we have communicated the application status. All applications must be completed and returned in 48 hrs of receipt with proof of income.

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********PROOF OF NEED INFORMATION TO FOLLOW (REQUIRED to submit proof of income with application – see page 4)***

Patient/Guarantor Signature: _____

Responsible Party Signature:
(if different than patient)

Date:

SECTION V: APPLICATION SUBMISSION

Completed applications and supporting documentation should be sent within 48 hrs or ASAP to the e-fax number below:

Attn: Financial Assistance Cboleaders@pocatlanta.com **or it can be securely faxed to *404-352-7446.***

If you have any questions during the application process, please contact the Surgery Center's Administrative Office (404)355-0743 and ask for the CBO Revenue Cycle Supervisor.

PROOF OF NEED:

Patients must also include with the application Proof of Gross Income (section I). Additional documentation from either section II can be submitted for review of determining the level of Financial Assistance.

I. **Proof of Gross Income** POSC will request proof of Gross Income for review of the Financial Assistance Application, including, without limitation, the following:

- Self Employed or Contract Employee: Most recent year tax return and most recent 90 days of bank statements for personal and business checking and savings accounts.
- Recent pay stub
- Current year W-2 form
- Written verification of wage from employer
- Written verification from public welfare agencies or other government agencies which can attest to the patient's Gross Income status for the past 12 months
- Social Security Award Letter
- Verification of Pension or Retirement income
- Alimony or Child Support Court Order or Divorce Decree
- Unemployment Income Notice
- State of Georgia separation notice and status of unemployment filing

- Letter of Support: If the patient has no Gross Income, he or she should provide written documentation from person(s) or entities who provide him or her daily living necessities (food, shelter, clothing).

II. **Monthly Expenses** POSC may request proof of monthly expenses as part of the review of the Financial Assistance Application, including, without limitation, the following:

- Utilities (electric, gas, cable, water/sewage/garbage)
- Auto Payments
- Insurance (home, renters, auto, health)
- Loans
- Credit Cards
- Medical Expenses