EMMITSBURG OSTEOPATHIC PRIMARY CARE CENTER, INC.

FINANCIAL HARDSHIP APPLICATION

2009 Federal Poverty Guidelines

Size of Family	U.S.	200%
1	$ 10,830	$ 21,660
2	14,570	29,140
3	18,310	36,620
4	22,050	44,100
5	25,790	51,580
6	29,530	59,060
7	33,270	66,540
8	37,010	74,020

**For families with more than 8 persons, add $3,740 for each additional person.*

Please provide copies of the following information so we may complete your application:

- MOST RECENT TAX FORMS (1040 AND/OR W-2)—THESE MUST BE SIGNED
- PAYROLL CHECK STUBS FOR THE PAST 30 DAYS FOR ALL PERSONS EMPLOYED WITHIN THE HOME
- UNEMPLOYMENT CHECK STUBS FOR THE PAST 30 DAYS
- DRIVERS LICENSE OR IDENTIFICATION CARD FOR ADULTS
- PROOF OF ALL OTHER INCOME RECEIVED WITHIN THE LAST 30 DAYS
- PROOF OF ALL OUTSTANDING BILLS (PAYMENT STUBS, CANCELLED CHECKS, ETC.)
- MEDICAID FORMS OR ID CARD
- ATTACHED FINANCIAL STATEMENT (COMPLETELY FILLED OUT AND SIGNED)

PLEASE BE SURE TO SIGN THE ATTACHED FINANCIAL STATEMENT—YOUR REQUEST WILL NOT BE PROCESSED IF THIS IS NOT SIGNED!

ALL ITEMS MUST BE RETURNED (AS APPLICABLE) ON THIS CHECKLIST (IN PERSON OR BY MAIL)

You will be notified within 14 business days of the determination of financial hardship.

EMMITSBURG OSTEOPATHIC PRIMARY CARE CENTER, INC.
FINANCIAL STATEMENT
PAYMENT PLAN/UNCOMPENSATED SERVICES APPLICATION

PATIENT NAME: _____ DATE(S) OF SERVICE_____

NAME OF RESPONSIBLE PARTY:_____

RELATIONSHIP TO PATIENT: _____

SPOUSE: _____ TELEPHONE: _____

ADDRESS: _____

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD): _____

EMPLOYER: _____ ADDRESS: _____

IF UNEMPLOYED, HOW LONG?: _____

SPOUSE'S EMPLOYER: _____ ADDRESS:_____

IF UNEMPLOYED, HOW LONG?: _____

OTHER FAMILY MEMBER EMPLOYER(S): (INCLUDE MEMBER NAME, EMPLOYER, &

ADDRESS:)_____

_____

MONTHLY FAMILY INCOME & SOURCE

	Patient	Spouse	Responsible Party	Children Working
Monthly Salary (Gross)				
Public Assistance Benefits				
Unemployment Benefits				
Social Security Benefits				
Workman's Compensation				
Child Support				
Other (Alimony, Etc.)				

TOTAL FAMILY INCOME $_____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE EMMITSBURG OSTEOPATHIC PRIMARY CARE CENTER, INC. TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____

SIGNATURE OF PERSON MAKING REQUEST DATE

_____

SIGNATURE OF SPOUSE/OTHER DATE

DO NOT WRITE BELOW THIS LINE – FOR OFFICE PERSONNEL USE ONLY

This document was received on _____ by _____.
(Date) (Name/Title)

Approved by physician or office manager_____
(Signature of Physician or Office Manager)