HORIZON SURGERY CENTER - BEACHES
CHARITY CARE DOCUMENTATION REQUIREMENTS

CHARITY CARE APPLICATION DOCUMENTATION

Horizon Surgery Center Beaches may require some or all of the following documentation based upon the individual Charity Care Application

Required Documentation

A. Charity Care Application and Patient Attestation Form

B. Proof of Income – from all sources, listing gross income for the most recent four-week period.

C. Copies of most recent Federal Income Tax Return.

D. Last two months on bank statements for savings accounts and checking accounts.

E. Cash balances as of the date of service from certificates of deposit, stocks, and bonds.

F. Number of dependents. Unborn children are not added to the family size. Death of a spouse or dependents will only be included in family size for the year of the death.

G. Insurance Cards for patients, spouse and/or children.

H. Personal ID for patients, spouse, children under 18, and/or full-time college students 21 and under. Identity can be Driver's License, Passport, Social Security Card, or Birth Certificate.

Other Documentation at the Request of Horizon Surgery Center Beaches

A. Assets including home, automobiles, boats, and real estate other than primary residences.

B. Monthly household expenses as well as loan payments.

C. Credit Bureau check on accounts balances of $2,000 or more.

D. Board of Assessment – Property Value check (as required).

HORIZON SURGERY CENTER BEACHES
FINANCIAL EVALUATION FORM

Account Number:		MR Number:

Patient's Name:_________________________ Social Security Number: ____________
Street Address:_________________________ Telephone #:____________

City:____________________ ST:________ ZIP: ____________

Please provide the following information completely and accurately. Information is subject to verification. ***Providing false information to defraud a facility/hospital for the purpose of obtaining goods or services is a misdemeanor.***

List All household member names	Date of Birth	Social Security Number	Relationship to patient	Employer

Monthly Income		Monthly Expenses	
Responsible Party's Gross Salary	$	Rent/Mortgage/Housing	$
Spouse's Gross Salary	$	Electricity	$
Investment Income	$	Water/Sewage	$
Child Support/Alimony	$	Telephone	$
Rental Property Income	$	Groceries	$
Annuities/Stocks/Dividends	$	Transportation (automobile+insurance)	$
Pension/Retirement/Unemployment	$	Medical Bills	$
Other:	$	Other:	$
Total Monthly Income	$	**Total Monthly Expenses**	$
Assets		**Liabilities**	
Value of Residence(s)	$	Residence Loan Balance/Mortgage	$
Checking Account	$	Balance Owed on Credit Cards	$
Savings/Money Market/CD's	$	Auto Loan	$
Value-Auto/Boat	$	Medical Bills (total outstanding)	$
Other:	$	Other:	$
Total Value of Assets	$	**Total Liabilities**	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance. If I am entitled to any action against or settlement from third party payors, I will take any action necessary or requested by Horizon Surgery Center Beaches to obtain such assistance and will assign to Horizon Surgery Center Beaches, and upon receipt will pay to Horizon Surgery Center Beaches, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Horizon Surgery Center Beaches will result in the denial of this application. I also authorize Horizon Surgery Center Beaches to check my credit history through the credit bureau, if deemed appropriate.

______________________________ ____________________
Signature of Patient (Responsible Party) Date

HORIZON SURGERY CENTER BEACHES
PATIENT ATTESTATION
SIGN BELOW WHATEVER MAY APPLY TO YOUR SITUATION

1. I attest that as of ________________(date) I have NOT received any income or filed any income tax returns.

____ __________________________
Patient/Responsible Party Relationship Date

2. I attest that I have NO ASSESTS (Bank accounts, CD's, Etc) through myself or any other party.

____ __________________________
Patient/Responsible Party Relationship Date

3. I attest that I am HOMELESS and have been HOMELESS since ____________________________
Date

____ __________________________
Patient/Responsible Party Relationship Date

4. I attest that I have NO MEDICAL COVERAGE through myself or any other party to cover the outstanding amount of my bills.

____ __________________________
Patient/Responsible Party Relationship Date

5. I attest that I am/was a Florida Resident at the time of services were received and I intend to remain an Florida Resident.

____ __________________________
Patient/Responsible Party Relationship Date

6. I AFFIRM THAT ALL INFORMIATION GIVEN ON THIS ATTESTATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

____ __________________________
Patient Responsible Party Relationship Date

____ _________________________
Interviewer Date