APPLICATION FOR WAIVER OF PAYMENT DUE TO ECONOMIC HARDSHIP

PLEASE RETURN THIS APPLICATION WITH ALL THE REQUIRED DOCUMENTATION TO:

C-med Ambulatory Surgery Center
2238 Drew St
Clearwater, FL 33765
OR SECURELY FAX TO
727-733-0169

ONCE APPLICATION IS RECEIVED BY YOU, THERE IS A 30 DAY MAX TIMEFRAME FOR SUBMISSION OF ALL REQUIRED DOCUMENTATION, IN ORDER TO BE CONSIDERED FOR OUR HARDSHIP PROGRAM.

Print name: ______________________________

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE THE CLEARWATER ORTHOPAEDIC ASC/CMED ASC TO VERIFY ANY INFORMATION CONTAINED IN THIS APPLICATION FOR THE SOLE PURPOSE OF DETERMINING FINANCIAL NEED.

____

PATIENT'S SIGNATURE **DATE:**

____

SPOUSE/OTHER SIGNATURE **DATE:**

APPLICATION FOR HARDSHIP PROGRAM

PATIENT NAME: ____
ADDRESS:____
CITY: ______________________ STATE: ___________ ZIP CODE: _______________
TELEPHONE: ________________________
EMERGENCY CONTACT: ____

INSURANCE COVERAGE

PRIMARY INSURANCE:__________________________POLICY#____________________

SECONDARY INSURANCE:_______________________POLICY#____________________

TO DETERMINE PATIENT ELIGIBLITY WE UTILIZE THE 2016 STATE OF FLORIDA POVERTY GUIDELINES AS PUBLISHED IN THE FEDERAL REGISTER

(SEE ATTACHED)

THE FOLLOWING DOCUMENTATION IS REQUIRED FOR FURTHER CONSIDERATION IN THIS PROGRAM

- COPY OF FLORIDA ID/DRIVER'S LICENSE.
- ALL BANK STATEMENTS REFLECTING TRANSACTIONS FOR THE PAST 3 MONTHS.
- PROOF OF INCOME ONE MONTH PAY STUBS OR UNEMPLOYMENT STUBS, OR
- PROOF OF ELIGIBILITY FOR SSD, SSI, MEDICAID OR GOVERNMENT ASSISTANCE.
- PREVIOUS YEAR'S TAX RETURN (PROOF OF FAMILY MEMBERS LIVING IN HOUSEHOLD, MUST BE CLAIMED ON TAXES).
- ADDITONAL RESOURCES MAY BE REQUESTED SHOULD THE NEED ARISE

PLEASE STATE YOUR PERSONAL COMMENTS BELOW:

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____
____
____
____

FINANCIAL DISCLOSURE FORM

PATIENT'S NAME: ________________________________ DATE OF BIRTH ___________

RESPONSIBLE PARTY'S NAME: ____

PHONE: (___) _____________ SSN# ______-______-________ # OF DEPENDANTS ____

EMPLOYER: ____

WORK PH# (____) ________-________.

SPOUSE'S EMPLOYER: ____

WORK PH# (____) _____-_________.

1. MONTHLY INCOME:

PATIENT/RESPONSIBLE PARTY INCOME:$______________________________________
SPOUSE INCOME:$____
OTHER INCOME:$____

2. MONTHLY EXPENSES:

RENT/MORTGAGE:$_________________________CHILDCARE:$__________________
AUTOMOBILE:$_________________UTILITTIES:$_______________________________
CREDIT CARDS:$____
OTHER EXPENSES:$____

3. ASSETS:

DO YOU (APPLICANT) OR YOUR SPOUSE OWN, ALL OR PART, OF ANY ASSESTS SUCH AS VEHICLES, BANK ACCOUNTS, TAX SHELTERED ACCOUNTS, PROPERTY, CERTIFICATES OF DEPOSITS (CD'S), CASH, IRA'S, 401K'S, BONDS, ANNUITIES, STOCKS, OR RECEIVED LARGE SUMS OF MONEY IN THE LAST 3 MONTHS? ____YES _____NO *IF YES, NEED DOCUMENTATION FOR ALL

PLEASE LIST ALL ASSETS AND VALUE BELOW - USE ADDITIONAL SHEET IF NEEDED:

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____

VEHICLE MAKE/MODEL: _____________________________________ YEAR: ______
DO YOU RENT_______ OR OWN______YOUR HOME?

I CERTIFY THE ABOVE INFORMATION IS CORRECT AND THE PAYMENT OF MY LIABILITY WOULD PRESENT A FINANCIAL HARDSHIP. I AUTHORIZE THE CLEARWATER ORTHOPAEDIC ASC/CMED ASC TO VERIFY ANY INFORMATION CONTAINED IN THIS APPLICATION FOR THE SOLE PURPOSE OF DETERMINING FINANCIAL NEED.

SIGNATURE OF PATIENT/GUARDIAN DATE:

HARDSHIP APPROVAL GUIDELINES

- **THIS HARDSHIP DOES NOT APPLY TOWARDS YEARLY DEDUCTIBLES. THIS IS DUE TO, YOUR INDIVIDUAL CONTRACT WITH YOUR INSURANCE CARRIER, AND/OR, OUR FACILITY'S CONTRACT WITH THE SAME; WHICH STIPULATES ALL MONIES APPLIED TOWARDS THE YEARLY DEDUCTIBLE MUST BE COLLECTED BY THE PROVIDER OF SERVICES RENDERED.**

- **ONCE YOUR APPLICATION HAS BEEN APPROVED, YOU WILL NOT BE RESPONSIBLE FOR ANY FUTURE COPAYS OR CO-INSURANCES FOR THE CURRENT PHYSICAL YEAR.**

- **A VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. PLEASE, BE AWARE OF THE TERMS OF YOUR INSURANCE POLICY PRIOR TO SERVICES BEING RENDERED BY OUR PROVIDERS.**

- **FOR THOSE MEDICARE PRIMARY WITH MEDICAID SECONDARY ELIGIBLE PATIENTS: PLEASE SUBMIT A COPY OF YOUR MEDICAID CARD ALONG WITH THIS APPLICATION.**

- **PLEASE BE ADVISED THAT WE ARE NOT STRAIGHT MEDICAID PROVIDERS, THEREFORE, THOSE PATIENTS WITH MEDICAID AS PRIMARY, WILL BE CONSIDERED SELF PAY AND FOLLOW THE SELF PAY FEE SCHEDULE.**

- **PLEASE BE AWARE ONCE THE HARDSHIP IS EXPIRED YOU ARE RESPONSIBLE FOR REQUESTING A RENEWAL HARDSHIP APPLICATION.**

I HEREBY ACKNOWLEDGE AND HAVE READ THE TERMS OF THE HARDSHIP PROGRAM.

PATIENT SIGNATURE: ____________________________________DATE: ______________

ANY BILLING QUESTIONS OR CONCERNS PLEASE CONTACT:
GINA MENZA; PATIENT ACCTS REPRESENTATIVE 727-797-7463 EXT 5149
EMAIL: gmenza@fsispine.com

GUIDELINES FOR MONTHLY BUDGET OPTIONS

COPAY BUDGET PLANS

BUDGET OPTIONS FOR COPAYS BASED ON AMOUNT DUE

- COPAYS OF $299.99 OR LESS

  1. REQUIRES 25% DOWN.
  2. BALANCE TO BE PAID WITHIN A MAX OF 3 MONTHLY PAYMENTS .
  3. PATIENT WILL SIGN A BUDGET AGREEMENT.

- COPAYS OVER $300.00

  1. REQUIRES 25% DOWN.
  2. BALANCE TO BE PAID WITHIN A MAX OF 6 MONTHLY PAYMENTS.
  3. PATIENT WILL SIGN A BUDGET AGREEMENT.

- FOR A SERIES OF INJECTIONS, WHERE MULTIPLE SERVICES WILL INCREASE BALANCE.

  1. PATIENT WILL STILL SIGN A MONTHLY AGREEMENT FOR EACH DOS.
  2. THE INITIAL MONTHLY PAYMENT WILL BE CONSIDERED THE MINIMUM MONTHLY PAYMENT DUE THROUGHOUT EACH SERIES.
     a. EXP: A PATIENT WITH A $250.00 COPAY WOULD HAVE A DOWN PAYMENT OF $62.50 THEN THREE(3) MONTHLY PAYMENTS OF $62.50. THEREFORE, $62.50 WOULD CONTINUE TO BE THE MINIMUM MONTHLY PAYMENT DUE UNTIL ALL SERVICES ARE PAID.
  3. ANY CHANGES TO PAYMENTS DUE REQUIRE ADMINISTRATIVE APPROVAL

GUIDELINES FOR MONTHLY BUDGET OPTIONS

DEDUCTIBLE BUDGET PLANS

BUDGET OPTIONS FOR DEDUCTIBLES BASED ON BALANCE

- DEDUCTIBLE BALANCES $750.00 - $2,499.99

  1. REQUIRES 10-15% DOWN.
  2. BALANCE TO BE PAID WITHIN A MAX OF 9 MONTHLY PAYMENTS.
  3. PATIENT WILL SIGN A BUDGET AGREEMENT.

- DEDUCTIBLE BALANCES OVER $2,500.00

  1. REQUIRES 10-15% DOWN
  2. REQUIRES ADMINISTRATIVE AND/OR DOCTOR APPROVAL FOR PAYMENTS BEYOND 9 MONTHS.
  3. PATIENT WILL SIGN A BUDGET AGREEMENT.

COINSURANCE BUDGET PLANS

BUDGET OPTIONS FOR COINSURANCE BASED ON AMOUNT DUE

- COINSURANCE DUE OF $299.99 OR LESS

  1. REQUIRES 25% DOWN.
  2. BALANCE TO BE PAID WITHIN A MAX OF 3 MONTHLY PAYMENTS .
  3. PATIENT WILL SIGN A BUDGET AGREEMENT.

- COINSURANCE DUE OVER $300.00

  1. REQUIRES 25% DOWN.
  2. BALANCE TO BE PAID WITHIN A MAX OF 6 MONTHLY PAYMENTS.
  3. PATIENT WILL SIGN A BUDGET AGREEMENT.

BUDGET OPTIONS FOR COINSURANCE BASED ON AMOUNT DUE CONTINUED

- FOR THOSE HAVING A SERIES OF INJECTIONS, WHERE MULTIPLE SERVICES WILL INCREASE BALANCE.

    1. PATIENT WILL STILL SIGN A MONTHLY AGREEMENT FOR EACH DATE OF SERVICE.
    2. THE INITIAL MONTHLY PAYMENT WILL BE CONSIDERED THE MINIMUM MONTHLY PAYMENT DUE THROUGHOUT EACH SERIES.
        a. EXP: A PATIENT WITH A COINSURANCE DUE OF $294.84 WOULD HAVE A DOWN PAYMENT OF $73.71 THEN THREE(3) MONTHLY PAYMENTS OF $73.71. THEREFORE, $73.71 WOULD CONTINUE TO BE THE MINIMUM MONTHLY PAYMENT DUE UNTIL ALL SERVICES ARE PAID.
    3. ANY CHANGES TO PAYMENTS DUE REQUIRE ADMINISTRATIVE APPROVAL