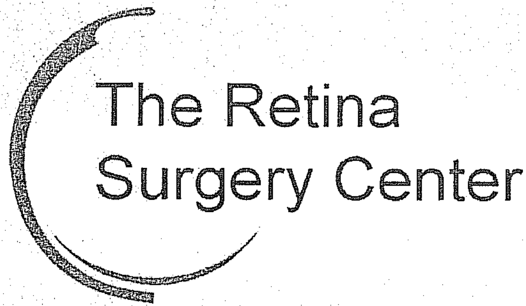

Patient Name ___________________________________

Patient Birthdate: ________________________________

I am requesting financial assistance with my surgery scheduled at The Retina Surgery Center on ________________________________ (Date.)

I understand The Retina Surgery Center's Charity Care Policy allows for financial assistance in certain situations related to my ability to pay.

The 2016 Poverty Guidelines:

Persons in family	150% Poverty guideline
1	**$ 17,820**
2	**$ 24,030**
3	**$ 30,240**
4	**$ 36,450**
5	**$ 42,660**
6	**$ 48,870**
7	**$ 55,095**
8	**$ 61,335**

For families with more than 8 persons, add $4,160 for each additional person.

I attest that my annual income is within the limits established above in the 2016 Poverty Guidelines.

______________________________ ______________________________

Patient Signature Date Signed

For Facility Use Only--

Charity Care amount awarded: ____

____

Charity Care Committee member Signature Date

Phone: 206.215.3850 Toll Free: 1-800-331-3719 Fax: 206.215.3870