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 2019 Poverty Guidelines:

Persons in family	150% Poverty guideline
1	**$18,210**
2	**$24,690**
3	**$31,170**
4	**$37,650**
5	**$44,130**
6	**$50,610**
7	**$57,090**
8	**$63,570**

For families with more than 8 persons, add $6,480 for each additional person.

I attest that my annual income is within the limits established above in the 2015 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

1750 112th Ave NE, Suite D050 Bellevue, WA 98004