The Center for Specialized Surgery

The following information is provided to the Financial Counselor as documentation for the necessity of charitable assistance.

Name: _____ Phone: ( ) _____

Address: _____ Age: _____

_____ Service Date: _____

Are You?
- ☐ Married
- ☐ Widowed
- ☐ Single
- ☐ Separated
- ☐ Divorced

Are You?
- ☐ Homeowner
- ☐ Renter
- ☐ Farm Owner
- ☐ Boarder
- ☐ Assisted Living

Are You?
- ☐ Retired
- ☐ Employed
- ☐ Unemployed

If currently employed, please provide employer information: _____

_____

If retired, what type of work did you do? _____

How many dependents do you claim (including yourself)? _____

Tell us about your monthly Gross Income:

What are your monthly gross earnings from Employment?	$
What is your monthly social security gross income?	$
What is your pension or retirement gross income?	$
What is your income from rental real estate?	$
What is your spouse's monthly income?	$
Other income not included in these categories	$
Monthly Income	**$**
	X 12 months
Total Annual Income	**$**

_____ _____

Patient or Authorized Party Signature **Date**

For Office Use Only

Date: _____			Completed By:_____
Comments:			
Adj Code: _____		TOS Payment $_____	
ASC ☐ Approved	Disc % _____	Disc $_____	Budget Plan Monthly_____
Anes ☐ Approved	Disc % _____	Disc $_____	Budget Plan Monthly_____