Dear Patient:

Thank you for choosing Eye Partners, P.C. d/b/a Eye Center South ("ECS") for your health care needs. ECS' Financial Hardship program is available to assist those patients determined to be in financial need, without regard to age, race, color, creed, sex, religion, ancestry, marital status, disability, national origin or other legally protected category. Eligibility is income-based. In order to process your application, the following documents will be needed:

1. A completed application for Financial Hardship.
2. Verification of all income, such as a copy of your most recent paycheck, Social Security and/or other governmental checks, pensions, child support checks, etc.
3. A copy of your most recent Federal income tax return.
4. A copy of your most recent bank (checking and/or savings) statement.
5. Driver's license or identification card.
6. Medicaid or other state-funded medical assistance, if applicable.
7. If you are unable to work, please provide a note from your physician confirming your inability to work.

We have enclosed an application for you to complete and return, along with the information requested above. All applications to this program are subject to verification. **If you provide false information your application will be denied and you will not be allowed to apply to the program in the future.**

If your application is approved, you will receive a letter notifying you that your account has been adjusted with an explanation of the amount waived or discounted and the remaining amount due. If your application is denied, you will be notified by letter. At that time, you will need to call and set up an acceptable payment arrangement on your account(s).

Once you have completed the application and gathered the required financial information, please return to the office. If there are any questions, please call Sherry McLean at 334-793-2211 ext. 274.

Sincerely,

Sherry McLean

Enclosure: Application for Financial Hardship

APPLICATION FOR FINANCIAL HARDSHIP

EYE PARTNERS, P.C. D/B/A EYE CENTER SOUTH

Please complete and return this form to: Sherry McLean at 2800 Ross Clark Circle, Dothan, Alabama 36301.

Attach the following documents:

1. **Verification of all income, such as a copy of your most recent paycheck, Social Security and/or other governmental checks, pensions, child support checks, etc.**
2. **A copy of your most recent Federal income tax return.**
3. **A copy of your most recent bank (checking and/or savings) statement.**
4. **Driver's license or identification card.**
5. **Medicaid or other state-funded medical assistance form, if applicable.**
6. **If you are unable to work, please provide a signed note from your physician confirming your inability to work.**

Date: ___________________________

I would like to apply for Financial Hardship under the provisions set forth by ECS.

1. Patient Name: ____

   First Middle Last

   Address:____

   Number & Street City State Zip

   Telephone: Residence (___)__________________ Business (___)______________________

   Employer/Employer's Address: ____

   ____

   ____

2. List all members of your household (including self):

Name	Age	Relation/Occupation

3. Household Income: Total/Monthly: Total/Yearly:

	Total/Monthly:	Total/Yearly:
Income* (Self)	$____________	$____________
Income* (Spouse)	$____________	$____________
Other (describe:___________________________)	$____________	$____________

* Income includes all salary, public assistance benefits, unemployment benefits, social security benefits, workers' compensation, child support payments, alimony and any other source of income.

4. Are you currently out of work? Yes ☐ No ☐.

If yes, do you anticipate going back to work in the next six (6) months? Yes ☐ No ☐.

If yes, when? ____

(Please note that you may be asked to provide a written statement from your employer regarding whether or not employment will be available and the estimated amount of your projected yearly income when you re-enter employment.)

5. Public Assistance:

A. Have you applied for Medicaid or other public assistance?__________________________

B. If yes, please identify/describe. ____

C. What was the approximate date of your application?_______________________________

D. What response have you received?____

6. Other Available Health Care Coverage and Benefits:

A. Have you exhausted all other available health care coverage and benefits? _____________

B. Please identify/describe. ____

I hereby request that my Application for Financial Hardship be reviewed by ECS. I understand that the information submitted herein, including, but not limited to, the account balances in any bank or savings and loan institutions, is subject to verification by ECS and therefore may need to be disclosed to a third-party for such purposes. I hereby consent and give express permission for any and all verification disclosures. I also understand that if the information that I have submitted is determined to be false, it will result in denial of my Application, and I will be liable for charges for services provided. I hereby agree to report any changes to my financial condition to ECS immediately.

By signing below, I hereby acknowledge that I have read this Application and understand the terms and conditions contained herein.

____ _________________________________

Signature (Patient) Date

____ _________________________________

Signature (Parent/Patient's Representative, if applicable) Date

Additional Comments:

____

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....

(Do Not Write Below This Line)

FOR ECS USE ONLY

Approved: ______________ **Denied:** ______________

Signature: ____________________________________ **Date:** __________________

Printed Name: ________________________________ **Title:** ________________________

Comments: ____

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