

Financial Assistance Application Instructions & Required Documents

Please attach the following information to your Financial Assistance Application. Complete all sections of the form before returning it to McLean Tysons Orthopedic Surgery Center (MTOSC), and include:

1. Two copies of your most recent pay stub(s), or a copy of your most recent income tax form (no more than 18 months old)
2. A copy of your lease, if applicable
3. Copies of your recent bank statements
4. Your family's annual gross income
5. The number of dependents in your family, including yourself

Please send all listed information with a signed and dated application. Incomplete applications will be denied.

Note: This application applies only to outpatient surgical procedures for the Center and does not apply to professional (physician/anesthesiologist) fees.

Return your application and supporting documents to:

McLean Tysons Orthopedic Surgery Center
Dept 3800
PO Box 986524
Boston, MA 02298-6524

Questions relating to Charity Care and Financial Relief can be directed to MTOSC business personnel or the following number: 833-360-9246 option 2

See also the Surgery Center Website for additional contact information: mctosc.com

Financial Assistance Application

Account #: _____

| |
|----------------------------|
| Patient Information |
|----------------------------|

Name: _____

Marital Status: _____

Address: _____

Employer: _____

Occupation: _____

Total Annual Income: _____

Total # of Dependents (including yourself): _____

| |
|--|
| Spouse or Responsible Party Information |
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Name: _____

Marital Status: _____

Address: _____

Employer: _____

Occupation: _____

Total Annual Income: _____

| Housing | Total Owed | Monthly Payment |
|---------------------|------------------------|-----------------|
| Mortgage or Rent | | |
| 2nd Mortgage | | |
| Phone | | |
| Electricity | | |
| Gas | | |
| Water/Sewer | | |
| Cable | | |
| Maintenance/Repairs | | |
| Subtotal | | |
| | Monthly Payment | |
| Transportation | | |
| Vehicle 1 Payment | | |
| Vehicle 2 Payment | | |
| Bus/Taxi Fare | | |
| Fuel | | |

| Loans | Total Owed | Monthly Payment |
|-----------------|------------------------|-----------------|
| Personal | | |
| Student | | |
| Credit Card | | |
| Credit Card | | |
| Credit Card | | |
| Other | | |
| Other | | |
| Other | | |
| Subtotal | | |
| | Monthly Payment | |
| Bank Accounts | | |
| Checking | | |
| Savings | | |
| Investment | | |
| Other | | |

| Other Insurance | Monthly Payment |
|------------------------|------------------------|
| Health | |
| Life | |
| Auto | |
| Home/Apt | |
| Subtotal | |

| | |
|-----------------|--|
| Subtotal | |
|-----------------|--|

| | |
|-----------------|--|
| Subtotal | |
|-----------------|--|

| Food | Monthly Payment |
|-----------------|------------------------|
| Groceries | |
| Dining Out | |
| Subtotal | |

I understand that the information I provided will only be used in the determination of my charges at MTOSC (covered medical care including for the ambulatory surgery center procedure) and will be kept confidential. I further understand that the documentation I submit as proof of income and assets will not be returned. I also understand that materials I submit concerning my family size and annual family income are subject to verification by MTOSC including, as necessary, obtaining financial information from employers, banks and other entities listed by me in my application.

I understand that if any information I have given is determined to be false, inaccurate, or incomplete, it may result in reversing the financial assistance approval and I will be responsible for the full amount of the charges. I understand that a Financial Assistance approval by McLean Tysons Orthopedic Surgery Center is subject to modification and/or retraction in the event that any material information was misstated, misrepresented, or omitted from the application. I further understand that any financial assistance provided is subject to recovery in the event of any third-party responsibility for the care, if a claim adjudication occurred resulting in insurance coverage for me, or if there are other material changes of circumstances following such approval.

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| <p>My signature below authorizes McLean Tysons Orthopedic Surgery Center to verify all information provided on this form. I/we have examined this application and certify that to the best of our knowledge the above information is true, accurate and complete.</p> |
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|---------|
| Patient |
|---------|

| |
|--------------------------|
| Responsible Party/Spouse |
|--------------------------|

| | | |
|-----------------------|-------|----|
| Applied for Medicaid: | Yes | No |
| Case Worker Name: | _____ | |
| Appointment Date: | _____ | |
| Medicaid #: | _____ | |
| Green Card: | _____ | |