HHC Southington Surgery Center, LLC d/b/a Cheshire Surgery Center
Free Care Guidelines and Application

The patient will need to complete a Charity Care Application and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1. Documented proof that patient is at or below 200 % of the current federal poverty guidelines. This can include documents such as:
    a. W-2 withholding statements
    b. Pay check stubs
    c. Income Tax return
    d. Forms from Medicaid or other State-funded medical assistance
    e. Forms from employers or welfare agencies.
2. Patient has other circumstances that indicate financial hardship. These can be situations such as:
    a. Proof of bankruptcy settlement
    b. Catastrophic situations (death or disability in family, divorce)

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines.

Completion of this application does <u>not</u> mean your request will be granted or that you will be relieved of financial responsibility.

All information relating to financial hardship requests will be kept confidential.

Financial Hardship Discount Information Needed. HHS Poverty Guidelines- Used to determine financial hardship based on income.

2022 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.
1	$13,590
2	18,310
3	23,030
4	27,750
5	32,470
6	37,190
7	41,910
8	46,630
For each additional person, add	4,720

Cheshire Surgery Center
765 West Johnson Ave
Cheshire CT 06410

Return to: Cheshire Surgery Center
PO BOX 956
Avon, CT 06001

Patient Name:	Date of Birth:
Address:	Phone Number:
Occupation:	SSN:
Number of Dependents Including Spouse: _____	Spouse Name:_____
Child:_____Child:_____	Child:_____Child:_____

INCOME (Annually Amount)	**EXPENSES (Monthly Amount)**
Salary Before Taxes) $_____	Rent/ Mortgage $_____
Income from All Other Employment $_____	Property Tax $_____
Rental Income $_____	Electric $_____
Social Security Benefits $_____	Gas/Propane $_____
Pension $_____	Water $_____
Unemployment Benefits $_____	Food $_____
Welfare $_____	Car Payment $_____
Worker's Comp or Strike Benefits $_____	Car Insurance $_____
Alimony/ Child Support $_____	Child Support $_____
Other Income $_____	Child Care $_____
TOTAL INCOME $_____	Medical Cost $_____
Note:	Pharmacy Cost $_____
PLEASE PROVIDE MOST RECENT W-2'S FOR	Charge Cards $_____
EACH WORKING MEMBER OF YOUR HOUSE-	(Total per month)
HOLD	Loans $_____
	Medical Insurance $_____
	Other: $_____
	TOTAL EXPENSES $_____

I am aware that this information will be used to determine my eligibility for assistance.

I certify that the above information is true and correct.

Signature of Applicant:_____ **Date:**_____