The Center

Exhibit A

CHARITY CARE APPLICATION

Patient Information

Patient's Name: ______________________________

Address: ______________________________

Date of Birth: ______________________________

Family Information

Number of family members living in household: __________

Name	Relationship	Age	Gender

Family Income

	Gross Income/Monthly
Wages (self)	__________
(spouse)	__________
(Other family members)	__________
Government Assistance	__________
Alimony	__________
Child Support	__________
Other Income	__________

TOTAL INCOME __________ /Monthly

FAMILY MEDICAL EXPENSES: __________ /Monthly

PROOF OF INCOME RECEIVED: Yes or No Received By: __________

- I/we declare under penalty of perjury that answers given are true and correct to the best of my/our knowledge.
- I/we agree to tell the provider of services, monthly, if there is any change to my/our income, expenses or # of persons in the household.
- I/we agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse The Center from proceeds of any litigation or settlement resulting from such act.
- I/we understand that if I/we do not qualify for uncompensated services, I/we will be personally liable for the charges rendered by The Center or I/we may appeal the decision in writing with additional documentation.

Signature of Guarantor: ______________________ Date: __________

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The Center Discount Assistance Granted:_______% off fee schedule. Date Approved: __________

Approved by: ____ The Center Location: __________