



ADVANCED CENTER for EYECARE
PATIENT FINANCIAL HARDSHIP APPLICATION

ACE abides by the contractual and legal obligations of health benefit plans to collect charges, co-pay, co-insurance, and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, ACE has adopted a policy of screening requests for discounts, delayed payment plans, or forgiveness of debt based on individual circumstances. In order to do this, we must ask for certain financial information.

Please complete the following form to the best of your ability and provide the following supporting documentation:

All information will be held confidential as per ACE's privacy policy.

Patient Name:
Guarantor name(s):
Number of dependants per guarantor household:
Phone:
DOB:
Number in school:
E-mail:

Type of Assistance Requested:

Reduced deductible
Discounted cash services
Reduced co-pay/co-insurance
Forgiveness of debt

Employment/Unemployment Information (for each adult family member):

Employer name:
Address:
Phone:
If unemployed, please state when employment terminated or if lay-off is temporary, indicate expected duration:

Assistance Received:

State financial assistance
WIC
Food Stamps
CHIP

Property/Investment Values:

Home
Other real estate owned
Land
Business
Livestock
Savings/stocks/bonds
Other Investments



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Please specify the reason for the hardship: (Must be completed)

Please complete the information in the following table based on average income and expenses over the last twelve months. For amounts paid annually, enter annual amount divided by twelve.

Household Financial Information

Monthly Income (after payroll deductions)		Monthly expenses (not including payroll deductions)	
Employment		Mortgage/rent	
Unemployment/severance		Auto/transportation	
Self-employment		Non-reimbursed work expenses (e.g., parking, tools)	
Interest/dividends		Insurances (e.g., life, homeowners)	
Pension/disability		Utilities (lights, water, gas, trash)	
Child support/alimony		Medications	
Short-term disability		Childcare	
Long-term disability		Credit cards	
Rental income		Child support/alimony	
Other income:		Personal property taxes (home, auto)	
		Other:	
Total average income		Total average expenses	



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By my signature below, I certify that this information is true and complete. I grant ACE permission to verify this information and acknowledge that completion of this form does not guarantee discount, payment plan, or forgiveness of debt.

Signed: _____ Date: _____

Reviewed by: _____ Date: _____

Approved for: _____

Next review date: _____