

Guthrie Broome Orthopedic and Spine Surgery Center, LLC
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 not 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

**Guthrie Broome Orthopedic
and Spine Surgery Center**

**400 West Commons Way
Johnson City, NY 13790**

Return to: Guthrie Broome Orthopedic and
Spine Surgery Center
400 W. Commons Way, Suite 100
Johnson City, NY 13790

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

<u>INCOME (Annually Amount)</u>
Salary Before Taxes) \$ _____
Income from All Other Employment \$ _____
Rental Income \$ _____
Social Security Benefits \$ _____
Pension \$ _____
Unemployment Benefits \$ _____
Welfare \$ _____
Worker's Comp or Strike Benefits \$ _____
Alimony/ Child Support \$ _____
Other Income \$ _____
TOTAL INCOME \$ _____

<u>EXPENSES (Monthly Amount)</u>
Rent/ Mortgage \$ _____
Property Tax \$ _____
Electric \$ _____
Gas/Propane \$ _____
Water \$ _____
Food \$ _____
Car Payment \$ _____
Car Insurance \$ _____
Child Support \$ _____
Child Care \$ _____
Medical Cost \$ _____
Pharmacy Cost \$ _____
Charge Cards \$ _____
(Total per month)
Loans \$ _____
Medical Insurance \$ _____
Other: \$ _____
TOTAL EXPENSES \$ _____

Note:

***PLEASE PROVIDE MOST RECENT W-2'S FOR
EACH WORKING MEMBER OF YOUR HOUSE-
HOLD***

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: _____