Patient Name ___________________________________

Patient Birthdate: ________________________________

I am requesting financial assistance with my surgery scheduled at The Retina Surgery Center on ________________________________ (Date.)

I understand The Retina Surgery Center's Charity Care Policy allows for financial assistance in certain situations related to my ability to pay.

The 2022 Poverty Guidelines

Persons in family	150% Poverty guideline
1	**$20,385**
2	**$27,465**
3	**$34,545**
4	**$41,625**
5	**$48,705**
6	**$55,785**
7	**$62,865**
8	**$69,945**

For families with more than 8 persons, add $4,720 for each additional person.

I attest that my annual income is within the limits established above.

______________________________ ____________________________

Patient Signature Date Signed

For Facility Use Only---

Charity Care amount awarded: ____

Charity Care Committee Member Signature Date

Phone: 206.215.3850 Toll Free: 1-800-331-3719 Fax: 206.215.3870

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