Associated Eye Care, Inc.
Financial Hardship Worksheet

Patient Name: ______________________________ Date of Birth: ________________

Family Size: __________ Annual Household Income: __________________

* A copy of the responsible party's most recent W2/SA1099 form AND federal tax return must accompany this worksheet.

Patient or Responsible Party Information

Name: ______________________________ Relationship to Patient: ____________

Address: ____________________________ Telephone: ______________________

____________________________ Cell Phone: ______________________

____________________________ Own _________ Rent ___________

Employer: ___________________________ Occupation: ______________________

Insurance Information

Insurance Company: ____

Insured's Name: _______________________ Relationship to Patient: _____________

Policy Number: ________________________ Group Number: ___________________

I certify that the above information is true and accurate and that this application is made to allow Associated Eye Care, Inc. to determine my eligibility for reduced out-of-pocket health care services.

Signature of Responsible Party: __________________________ Date: _____________

Associated Eye Care use only:

Annual Income_________________________ Household Level___________________

Qualified Reduction_____________________

Signature: ______________________________________ Date: __________________