

**Lawrenceville Surgery Center
Financial Assistance Program
Qualification Form**

Patient Name/Date of Birth: _____

Spouse Name/Date of Birth: _____

Address _____

City, State, Zip _____

Parent/Guardian name(s) and date of birth:

Children/Dependent(s) name (list all in household) and date of birth:

Home phone _____ Cell phone _____

Work phone _____ Email address _____

Total members of household _____

Total annual family income (include all household members) \$ _____

Please provide the following information:

- Last 2 paycheck stubs for entire household
- Last year income tax records (W-2's for entire household and income tax return)
- Last 3 bank statements (computer print outs are acceptable)

You will be contacted if additional information is needed.

Mail or deliver to:

Lawrenceville Surgery Center
Attn: Casey McFarland
758 Old Norcross Road # 125
Lawrenceville, GA 30045

I certify that the above information is true and correct

Patient/Guardian Signature

Date