

LAWRENCEVILLE SURGERY CENTER
Financial Assistance Program
Written Statement

Patient Name/Date of Birth: _____

Address: _____

City/State/ZIP: _____

I, _____, do hereby declare one or more of the following:
Patient Name/Guardian Name

_____ I do not have a social security number

_____ I did not file Federal or State Income taxes for the year of 20_____

_____ I am currently unemployed and have no income.

_____ I have been unemployed for _____ years _____ months

_____ I used to work at _____ and left my
Company Name
employment because:

_____ of my injury _____ I was terminated _____ I quit

_____ Other (please explain): _____

_____ I do not have a bank account.

_____ My information has not changed since my initial approval on _____
Date approved for Financial Assistance

I certify the above information is true and correct.

Patient Signature: _____

Date: _____

EWSC Representative Signature

Date