the endo center at Voorhees

93 Cooper Road
Suite 100
Voorhees, NJ 08043

Sometimes proper medical care may seem to be out of reach due to extraordinary financial difficulties or circumstances. In our facility, we are concerned that our patients receive appropriate care, even if they are experiencing financial hardships.

In order to assist you, I will need you to complete the enclosed Financial Assistance Form and return to me, along with a copy of your last (2) bank statements, a copy of last two (2) pay stubs (if still employed), proof of unemployment benefits (if on unemployment), or a W-2 or Social Security Benefits Statement. Upon receipt of this information, I can determine what percentage of discount, if any, I can offer you. Enclosed is a postage-paid envelope for your convenience.

Please return all paperwork within two weeks to the address above. If you fail to provide ALL necessary documentation, your request will be denied.

If you have any questions, please feel free to contact me at 856-770-1920 option 5.

Respectfully,
The Endo Center at Voorhees
Billing Department

The Endo Center At Voorhees

Application for Financial Hardship Program

PATIENT INFORMATION		
Last Name	First Name	MI
Street Address		
City	State	Zip Code
Date of Birth	Social Security Number	Gender(M/F)

RESPONSIBLE PARTY		
Last Name	First Name	MI
Street Address		
City	State	Zip Code
Telephone Number	Social Security Number	Relationship

INSURANCE INFORMATION

	Yes	No
1-) Are you covered under any health insurance, including foreign coverage?	☐	☐

INCOME INFORMATION

Please indicate if earnings are weekly (W), monthly (M) or annual (A).

EARNED INCOME

Name of family member:	Name and address of employer	Gross Earnings	How often
1-)			M A
2-)			M A
3-)			M A

OTHER INCOME

Source	Amount	How Often
Social Security		M A
Retirement Benefits		M A
Pensions		M A

Source	Amount	How Often
Alimony		M A
Child Support		M A
Other Income		M A

Number of persons living in household	

*** Please attach copies of the latest paycheck stub or other income source and last 2 month bank statements ***

I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, The Endo Center at Voorhees may, at its own discretion, withdraw this speical discount and the full amount of the bill will become due and payable.

Applicant's Name (Please print)	Applicant's signature	Date

For Facility Use Only

Total Verified annual income: _____ **Approved by:** _____

Discount % to be taken: _____ **Good Until:** _____

Patient Account #