Connecticut Orthopaedic Surgery Center
Milford

Financial Affidavit Application

Patient Name:	Date of Birth:
Address:	Phone Number:
Occupation:	SSN:
Number of Dependents Including Spouse: _____	Spouse Name:_____
Child:_____Child:_____	Child:_____Child:_____

INCOME (Annually Amount)	**EXPENSES (Monthly Amount)**
Salary Before Taxes) $_____	Rent/ Mortgage $_____
Income from All Other Employment $_____	Property Tax $_____
Rental Income $_____	Electric $_____
Social Security Benefits $_____	Gas/Propane $_____
Pension $_____	Water $_____
Unemployment Benefits $_____	Food $_____
City/State Assistance$_____	Car Payment $_____
Worker's Comp or Strike Benefits $_____	Car Insurance $_____
Alimony/ Child Support $_____	Child Support $_____
Other Income $_____	Child Care $_____
TOTAL INCOME $_____	Medical Cost $_____
	Pharmacy Cost $_____
	Charge Cards $_____
	(Total per month)
	Loans $_____
	Medical Insurance $_____
	Other: $_____
	TOTAL EXPENSES $_____

► **NOTE: PLEASE INCLUDE MOST RECENT W2 AND TAX FORMS**

SPOUSE INCOME IS REQUIRED

I am aware that this information will be used to determine my eligibility for assistance.

I certify that the above information is true and correct.

Signature of Applicant:_____