You may be eligible to receive discounted care: Complete the application to help Green Springs determine eligibility for our Compassionate Care Program. By completing and signing, the patient acknowledges that he or she has made a good faith effort to provide accurate information requested in the application to assist Green Springs Medical in determining eligibility for financial assistance.

Name_____ Email_____ DOB_____

Address_____ Phone # _____

Rent or Own? _____ Monthly income _____ Household size _____

Are you employed _____Where do you work? _____

Do you receive/amount SSI_____ Disability _____ Other benefits_____

What is your diagnosis? _____

_____

What symptoms do you experience? _____

_____

What medications do you take? _____

_____

What is your level of pain on scale of 1-10? _____

Please explain why you are requesting assistance_____

_____

Any other information you would like to include? _____

_____

Signature_____Date_____