APPLICATION FOR FINANCIAL ASSISTANCE

Please provide complete information below.

Patient Information

Last Name: First Name: Middle Initial:

SSN: Phone: Date of Birth ______ / ______/ ________

Address:

City: State: Zip:

Responsible Party (if different than above)

Name: Phone:

Address:

City: State: Zip:

Income Information (last 12 months)

Patient's Gross Family Income: Family Size:

Other Family Income:

Family Income Total:

I certify the above information is true and accurate to the best of my knowledge. Further, I will make an application for any assistance (Medicare, Medicaid, Insurance, etc.) which may be available for payment of my hospital bills, and I will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

☐ *I give permission to the hospital to run a credit check in order to verify information for the application process.*

Applicant Signature: **Date:**

Your completed FA Packet should include the following items. You will be contacted if anything further is needed.

☐ Copy of Driver's License or State issued identification card

☐ Proof of Address (e.g. utility bill)

☐ Copy of the DFACS denied application for assistance

☐ Copy of Employer's Check Stub or W-2

☐ Previous years Income Tax Statements

☐ Copies of outstanding medical bills

☐ Original signed application

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For Office Use Only

Admission and Patient Information

Patient Name: ______________________

Dates of Service: ______________________

Greater than 125% Amount: ______________ Less than 200% Amount: ______________

Total Hospital Charges: ______________________

Amount Collected from Third Party(ies): ______________________

Amount Due: ______________________

Eligibility Determination

Date Application Received: ______________________

Income Verified? ☐ YES ☐ NO

Qualify for Indigent Care? ☐ YES ☐ NO

Qualify for Charity Care? ☐ YES ☐ NO

Amount of Uncompensated Services to be Provided: ______________________

Application Determination (circle one)

☐ Approved ☐ Denied

Reason: ______________________

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Date of Final Determination of Approval: ______________________

Date Applicant Notified: ______________________