

## Financial Assistance Application Form

To be considered for financial assistance you **must provide** the following\*:

- A completed and signed Financial Assistance Application.**
- Proof of Income:** (Please provide each of the following or an explanation of why not provided)
  - Federal Income Tax return(s) for your household for the most recent calendar year.
  - Bank Statements for all bank accounts for the last 2 months
  - Two (2) most recent pay stubs or a statement from your employer regarding your income.
    - If self-employed**, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.
    - Unemployment statement showing denial or eligibility and amount receiving.
  - Written documentation of all forms of income. (i.e. trust funds, stock dividends, child support, alimony, social security, public assistance, food stamps, etc.)
    - If you have not had any income for the past three (3) months or there has been a recent change in your financial situation you **must** include a statement or letter explaining your situation. If someone else is supporting you, they must sign the support statement on page 4 of the application.
- Identification:**
  - Two forms of identification. (i.e. driver's license, government issued photo ID, social security card, birth certificate or pass-port)
- Any other information that demonstrates financial hardship or need for financial assistance.** (i.e. public assistance award or denial letters, letters of support, bank statements, etc)

\* If, for any reason, you cannot provide us the information requested, please attach a written statement explaining why you cannot provide this information.

Send completed applications and documentation to:

**St. Mary's Health Care System, Inc.**  
**Attn: Patient Access**  
**1230 Baxter Street**  
**Athens, GA 30606**

**OR**

**FAX: 706-389-3151**

Failure to submit all requested information may result in denial of your application. Applications should be returned within **14** days or requests may be denied.

Please note that if financial assistance is granted it will only cover your medical bills from our facility. It will not apply to the bills for other medical providers, hospitals or physicians unless they specifically agree to accept it. **PLEASE CONTACT THE OTHER MEDICAL PROVIDERS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.**

When applying for financial assistance you are giving consent for us to make necessary inquiries to confirm financial obligations or references. If you have any questions, **please contact one of our financial counselors at 706-389-2020.**

## Financial Assistance Application

Date: \_\_\_\_\_

### Patient Information

**Acct Number(s):** \_\_\_\_\_ **Total Amount Due:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Spouse or Guarantor Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Years/months at residence: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

### Household Information

Member Name	Age	Relationship	Employer	Annual Gross Income
		SELF		\$
				\$
				\$
				\$
				\$

**Total Family Size:** \_\_\_\_\_ **Total Dependents:** \_\_\_\_\_ **Total Household Income: \$** \_\_\_\_\_

### Screening Information:

- ❖ Do you currently have health insurance? (Y/N)\_\_\_\_ If yes, please provide insurance info below:
  - Insurance Name: \_\_\_\_\_ ➤ Policy # \_\_\_\_\_
  - Group Name/Number: \_\_\_\_\_
- ❖ Have you had health insurance that has been terminated in the past 3 months? (Y/N)\_\_\_\_ If yes, complete the following:
  - What type of insurance? (i.e. Medicaid, BCBS, Tricare, etc,) \_\_\_\_\_
  - Reason for insurance termination? \_\_\_\_\_
  - Did you apply for cobra insurance coverage? (Y/N) \_\_\_\_\_ If so, when? \_\_\_\_\_
  - Former Employer Name: \_\_\_\_\_
- ❖ Are you active duty or retired military? (Y/N)\_\_\_\_ If so, are you eligible for VA Benefits? (Y/N)\_\_\_\_
- ❖ Have you applied for Medicaid or Disability? (Y/N)\_\_\_\_ If yes, complete the following:
  - When? \_\_\_\_\_ ➤ Where? \_\_\_\_\_
  - Caseworker? \_\_\_\_\_
  - Has your household or income status changed since you last applied? (Y/N)\_\_\_\_
- ❖ Were you a victim of a crime? (Y/N)\_\_\_\_ If yes, complete the following.
  - Have you filed a Police Report? (Y/N)\_\_\_\_ (Must be filed within 72 hrs of incident)
  - Completed Victim of Crime application? (Y/N)\_\_\_\_
- ❖ If you have any other special circumstances which you would like us to consider when reviewing your application, please explain below:

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### Financial Assessment

Account Number(s) \_\_\_\_\_

Patients Name \_\_\_\_\_ Date: \_\_\_\_\_

**Monthly Expenses**

Rent/Mortgage	\$ _____
Utilities	\$ _____
Food	\$ _____
Cell Phone/Pager	\$ _____
Cable	\$ _____
Auto Loan	\$ _____
Auto Insurance	\$ _____
Loans	\$ _____
Child Support	\$ _____
Credit Cards (Min Payment)	\$ _____
Other	\$ _____
	\$ _____
	\$ _____

**Assets**

Checking Account(s)	\$ _____
Savings Account(s)	\$ _____
Other Cash Assets	\$ _____
Credit Cards (Available Credit)	\$ _____

**Monthly Gross Income**

Employment Income	\$ _____
Spouse Income	\$ _____
Retirement Income	\$ _____
Food Stamps	\$ _____
Government Benefits	\$ _____
Child Support	\$ _____
Other	\$ _____

**Total Expenses**      \$ \_\_\_\_\_

**Total Income**                      \$ \_\_\_\_\_

**TOTAL MONTHLY INCOME**              \$ \_\_\_\_\_

**TOTAL MONTHLY EXPENSES**              \$ \_\_\_\_\_

**AMOUNT AVAILABLE**                      \$ \_\_\_\_\_

**Patient/Guarantor Certification**

I, \_\_\_\_\_, CERTIFY the information I have provided is true and accurate to the best of knowledge. I understand that if I do not cooperate with the hospital in supplying ANY additional requested information; my application may be denied for possible financial assistance. I understand that the information which I submit is subject to verification by the HOSPITAL, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I understand that this application pertains to hospital charges and not physician's charges. I understand that if any information I have given proves to be untrue, the HOSPITAL will re-evaluate my financial status and take whatever action becomes appropriate. I am also aware that I am only applying for the accounts specified above, and that my financial status will have to be reevaluated and may require a new application for any/all future treatment I receive at St. Mary's Health Care System, Inc.

 \_\_\_\_\_  
 Patient/Guarantor Signature

 \_\_\_\_\_  
 Date

***For Office Use Only***	
Reviewed by: _____ Date _____ Recommendation: <input type="checkbox"/> Charity: _____% <input type="checkbox"/> Indigent <input type="checkbox"/> Denied: Reason _____	Approved by: _____ Date _____ _____ Date _____ _____ Date _____

**Additional Financial Documentation**  
(Only completed when applicable)

Account Number(s) \_\_\_\_\_

Patients Name \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ **Support Statement:**

My signature will certify that I, \_\_\_\_\_, do provide all necessary essentials for living for the patient's behalf, and have done so for a period of \_\_\_\_\_ years / months.

\_\_\_\_\_  
Signature of Patient's Supporter

\_\_\_\_\_  
Relation to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_ **Homeless Affidavit**

I, (PRINT NAME) \_\_\_\_\_ hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_ **No Changes to Financial Status since Previous Application for Assistance**

I, (PRINT NAME) \_\_\_\_\_ hereby certify there have been no changes to my (nor my spouse's) financial status since my previous application for financial assistance from St. Mary's which was completed on \_\_\_\_\_. Please select of the following options:

- I am still being supported by another. They do provide all necessary essentials for living for my behalf, and have done so for a period of \_\_\_\_\_ years/months.
- I am still Homeless. I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.
- There are no changes to my (or my spouse's) income or household size since my previous application.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date