



Financial Assistance Application Form

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

1. A completed and signed Financial Assistance Application.
2. Copy of your most recent bank statement for ALL of your bank accounts (**showing balance and activity for at least 60 days**).
3. Copy of your previous year's Federal Tax Return.
4. Copies of your 2 most recent pay stubs to validate household income. *(If you are self employed, provide copies of **three months Profit and Loss Statements** if available).*
5. Supporting documentation of all forms of income. *For example; public assistance award or denial letters, alimony court orders, social security award letter, unemployment benefit letter, etc.*
6. All College Students must supply the following:
 - a. Copies of all grants and/or loans
 - b. Living expense allotments granted by scholarships
 - c. Documentation from parents if they assist with living expenses
7. **If you are claiming no income** or there has been a recent change in your financial situation you **must** include a letter of explanation. If someone else is paying for your food and shelter, they must sign the support statement on page 4 of the application. **Also**, please verify that you have no source of income and how long it has been since you have not had a source of income. Examples of verification may include but are not limited to: current tax return, letter from a professional business, bank statements showing no deposits/withdrawals, Medicaid determination letter, etc.
8. Two forms of identification. *For example, driver's license, government issued photo ID, social security card, birth certificate or pass-port.*

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

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:

- Primary Language? English Spanish Other: _____
- Do you have insurance? (Y/N) _____ If yes, verify and update information for billing.
 Insurance Name: _____ Policy # _____
 Group Name/Number: _____
- Military Background / VA Benefits? (Y/N) _____
- Have you had insurance in the past (3) months? (Y/N) _____ If yes, complete the following:
 - What type of insurance? (i.e., Medicaid, BCBS, Tricare, County Program) _____
 - Reason for termination? _____
- Have you applied for:
 - Cobra Insurance coverage? (Y/N) _____ When? _____ Former POE: _____
 - Medicaid/Disability? (Y/N) _____ If yes, complete the following:
 - (a) When? _____ (b) Where? _____
 - (c) Caseworker? _____
 - (d) Has your living and/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 VOC application? (Y/N) _____
- If you have any other special circumstances which you would like us to consider when reviewing your application, please explain below:



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:

Charity: _____%

Indigent

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