



FINANCIAL ASSISTANCE APPLICATION

You may be eligible for financial assistance under the Federal Poverty Income Guidelines, complete this application and return it with the requested documentation listed below.

Provide ALL income verification listed below that applies to your Family Unit. (applicant/patient, spouse/significant other, and legal dependents).

- ___ **Wages:** Check stubs or statement from your employer indicating the last three (3) checks showing the gross income.
- ___ **Self-Employed:** If you and/or your spouse are self-employed, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.
- ___ **Unemployed:** Department of Labor Wage Inquiry from your local Department of Labor. Picture identification will be required.
- ___ **Social Security:** 3 of your most recent bank statements. If you do not have a checking account we need 3 verifications of deposits to your bank card issued by social security
- ___ **Tax Returns:** Previous year's income tax return, or _____
- ___ **Other Income:** Proof of any other income source such as child support, alimony, trust funds, or rental property.
- ___ **No Income:** If you have not had any income for the last three (3) months, please send:
 - ___ A statement from the person(s) providing food and shelter.
 - ___ **Other:** _____

Failure to submit the requested information may result in denial of your application because your financial eligibility could not be determined. This application is valid for 180 days from your request for Financial Assistance.

Approval under the Financial Assistance Program is effective for charges incurred from Coffee Regional Medical Center only. The program does not cover physician charges such as Pathology, Cardiology, Radiology, private physicians, or prescription medication.

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|---|-----------|---|-----------|--------------------------------------|
| <u>Return application and income proof to:</u> | <u>OR</u> | <u>Mail the application and income proof to:</u> | <u>OR</u> | <u>Fax to:</u> |
| Coffee Regional Medical Center Patient Financial Services (PFS) 196 Westside Drive Douglas, GA 31533 | | Coffee Regional Medical Center Patient Financial Services (PFS) Attn: Financial Counseling P O Box 1227 Douglas, GA 31534 | | 912-383-6917 Financial Counseling |

NOTE: Financial assistance will not be considered without income proof and the completed application signed.



FINANCIAL ASSISTANCE APPLICATION

Applicant/Patient: _____

Social Security #: _____ - _____ - _____

Mailing Address: _____

City/State: _____ Zip: _____

Street Address: _____

City/State: _____ Zip: _____

Home Phone #: () _____ - _____

Cell Phone # () _____ - _____

List Members of Family Unit: (defined as applicant, spouse, and all legal dependents as allowed by the Federal Government)

| Family Member Name | Birth Date | Gender | Relationship to Patient | Social Security Number | Employed (Yes / No) | Gross Monthly Income |
|--------------------|------------|--------|-------------------------|------------------------|---------------------|----------------------|
| | | | SELF | | | |
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Other income source(s) that you receive monthly:

SSI (Supplemental Security Income) \$ _____
 SSDI (Social Security Disability) \$ _____
 Unemployment \$ _____
 Food Stamps \$ _____
 Welfare (AFDC) \$ _____
 (VA) Veteran's Benefits \$ _____
 Pensions/Retirement Benefits \$ _____
 Child Support \$ _____
 Interest/Dividends On Investments \$ _____
 Other Income: \$ _____

Assets:

Savings Accounts(s) \$ _____
 Checking Account(s) \$ _____
 Stocks/Bonds (market value) \$ _____
 Certificate of Deposit(s) \$ _____
 Recreational Vehicles \$ _____
 Cars/Trucks \$ _____
 Other Assets: \$ _____

Monthly Household Living Expenses:

MORTGAGE/RENT:
 Mortgage/rent monthly payment \$ _____
 Property taxes/insurance _____
 Appraisal value of home \$ _____
UTILITIES: (water, garbage, electric, gas, gas, cable, and phone/cell) \$ _____
Groceries \$ _____
TOTAL AUTOMOBILE PAYMENTS:
 1st Automobile payment \$ _____
 2nd Automobile payment \$ _____
CREDIT CARDS: \$ _____
LOANS: \$ _____
INSURANCE PREMIUMS:
 Life \$ _____
 Medical \$ _____
HEALTHCARE EXPENSES:
 Medical Bills \$ _____
 Dental Bills \$ _____
 Prescriptions \$ _____
CHILD CARE EXPENSES: \$ _____
OTHER EXPENSES: \$ _____

If you have not listed income, please explain how you are paying for food and housing:



196 Westside Drive
 P.O. Box 1227
 Douglas, GA 31534-1227
 (912) 384-1900
 FAX: (912) 383-6917

DISCLAIMER

By signing below, I agree that I have read and understand the following as it relates to my application for the Financial Assistance Program (FAP) at Coffee Regional Medical Center (CRMC).

- * Incomplete applications and/or documentation of income will result in a denial of my application.
- * Financial Assistance will only cover bills for CRMC charges.
- * It is my responsibility to immediately notify CRMC Financial Counseling or Patient Financial Services of any additional services provided within thirty (30) days from the date of this application.
- * The billing process will continue on my total balance due until notification of approval.

The information given is true and correct to the best of my knowledge. I understand that any false statements given by me to receive assistance to which I am not entitled may disqualify me from this program and any funds utilized through this program will be voided.

Information provided will be used for the purpose of evaluating my financial condition and ability to pay any bills or charges for hospital services that I have received from Coffee Regional Medical Center or any accounts which I have signed as Guarantor. I authorize my employer to release information regarding my income which may be necessary in evaluating my financial needs. I agree to promptly notify Coffee Regional Medical Center of any changes in my financial status affecting my ability to pay. By requesting financial assistance, I understand Coffee Regional Medical Center may inquire into my credit history.

Signature of Applicant: _____

Date: _____

Do Not Write Below This Line For Hospital Staff Use Only.

Summary and Analysis Description

1. Annual Family Income \$ _____ Approved Date _____
 2. Number in Household _____ Denied Date _____
 3. % of Charity Allowed _____ **(Does not meet financial guidelines)**
 4. Adjustment Code _____ Medicare () Yes

() Initial App FAP Staff Signature: _____ Date Notice Mailed: _____

() Re-Validation {after 90 days of initial application} () Re-Consideration

() In person () On phone () Changes **Notate on 1st page of application**

PFS Staff Signature: _____ Re-Validation Date : _____ *Send to FAP.

FAP Staff Signature: _____ Approved Date _____

% of Charity Allowed _____ Denied Date _____

Adjustment Code _____ **(Does not meet financial guidelines)**

Pending: _____

Request Date: _____ () In person () On phone () By letter Staff Initials _____