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 hosptial 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 _____

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			

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:

_____

_____

Please turn to back of this page. ►