Clinch Memorial Hospital
P.O. Box 516, Homerville, GA 31634

Financial Assistance Application Checklist

Phone# (912) 470-2405

Please read the following information carefully. Note that all requested information must be included with the application prior to processing. An incomplete application will result in denial. Timelessness is extremely important.

Please use the following checklist to make sure you have all the required information before submitting your application.

Proof of Income:

Most recent Federal Income Tax forms - required for every application

If anyone in your household (including children under 21) is employed outside the home, the last 4 paycheck stubs are Required.
**If your child is employed and under age 21, proof of income may be in the form of a pay stub or certified letter.
**If you are not married, but live with someone and have children in common, then his/her income must be included.
**If you are legally separated, you must provide legal documentation of separation or include your spouse's income verification.

Proof of Worker's Compensation; Sick leave; Disability Compensation; Welfare; Social Security Retirement (SSI}; Child Support, or Alimony - if applicable.

If you are not employed and have no income, a NOTARIZED statement is required from the person who provides Room and board for you and your family.

If you lost your job in the last three months, a separation notice from your employer is required. **Additionally,** you will need to provide a letter from the Georgia Department of Labor Career Center specifying whether you are receiving unemployment benefits or not.

Proof of Address:

The following may be used for proof of address (at least 2): 1} Valid Georgia Driver's license, 2) Georgia Identification Card, 3) current Utility Bill (i.e. electric, water, phone, etc.), 4) Current Lease or rental receipt, Which should include the County of residence, 5) County Property Tax Assessment, 6) County Food Stamps Letter, 7) Voter Registration Card.

Miscellaneous:

If you list any children, other than biological or stepchildren, on the application, you must provide legal documentation Showing your relationship to the child.

If there is **no** household income listed, you are required to apply for assistance with other entities, such as Medicare, Medicaid, or Disability, and provide proof of denial before Indigent or Charity care can be approved.

All information must be returned as soon as possible. This application is not a guarantee that your account will not follow our collection process. You will continue to receive statements until the application is approved. If you do not complete the entire process, your account could be placed at the collection agency for legal collection purposes. Once that happens, you will not be eligible for the Financial Assistance Program.

You will receive an approval or denial letter upon completion of the application review.

Sincerely

Clinch Memorial Hospital
Financial Services

CLINCH MEMORIAL HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

Today's Date | Social Security#	Date of Birth	Patient Name	Sex
|			

Account#	Marital Status (check one)	Home Telephone#
	□ Married □ Single □ Divorced □ Widowed	
Address	City, State, ZIP	Cell/Alternate Phone #

Parent/Guardian Name (lfpatientlumder21)	Phone#	Address	City, State, ZIP

Parent or Guardian Employer	Work Phone#	Employer Address	Type of Work

Spouse's Employer	Work Phone#	Employer Address	Type of Work

Do you have Insurance Coverage?	Medicare	Medicaid	SSI Disability	Are you or your spouse Self Insured?
□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes

Do your children have Insurance?	**Do your children have Medicaid?**
□ No □ Yes	□ No □ YES Check one: □ Medicaid □ Wellcare □ Amerigroup □ Peach State

List All members of your household below (including yourself).

1.			
2.			
3.			
4.			
5.			
6.			

If more than 6 in household, please list the remaining members on a separate sheet of paper.

ASSETS- Please fill in ***each*** line, write N/A if not applicable to you.
*You must provide proof of the assets listed below. *

Checking Account Balance: $	Real Estate Equity: $
Savings Account Balance: $	Auto Equity: $
CD's: $	**401K:** $
Other (please specify):	

LIABILITIES- Please fill in ***each*** line, write N/A if not applicable to you.
*You must provide proof of the liabilities listed below. *

Rent/ Mortgage: $	Car Payment: $
Electricity Bill: $	Telephone Bill: $
Gas Bill: $	Insurance (Health): $
Water Bill: $	Medicine Expense: $
Other (please specify):	

INCOME INFORMATION - Please provide last 4 paycheck stubs of ***all employed*** (including children) members of household. A copy of the most recent federal income tax return filed. **Proof** of workers compensation, sick leave, disability compensation, child support, alimony, welfare, or social security retirement **(SSI),** if applicable.

Name	Source of Income	Amount	Pay Frequency
Patient:			□ Monthly □ Weekly □ Bi-weekly
Spouse:			□ Monthly □ Weekly □ Bi-weekly
Child:			□ Monthly □ Weekly □ Bi-weekly
Child:			□ Monthly □ Weekly □ Bi-weekly
Child:			□ Monthly □ Weekly □ Bi-weekly
Other (please specify):			

Financial Assistance Application

CO11sent. Authorization. ani:I Attestatio :

Please read and initial each line below:

I certify that this form has been examined by me and that the information is true and accurate to the best of my knowledge.

I, and my Spouse if applicable, agree to provide Clinch Memorial Hospital with any written documentation Needed to verify the information provided on the application and hereby grant permission for Clinch Memorial Hospital personnel to obtain such information on my/our behalf.

I understand that additional information may be requested in order to process this application.

I understand that I must first apply for any other benefits, which might pay for the services received at Clinch Memorial Hospital before Financial Assistance can be approved (i.e., Medicare, Medicaid, Disability, etc.)

I understand that any assistance provided is for my benefit only and will be based solely on the information Disclosed. No release or write-offs is granted in connection with any third party liability, whether the liability Arises by contact or negligence.

I understand that if I provide false information, any assistance previously granted will be reversed and **LEGAL ACTION** may be pursued.

I understand that the hospital may obtain my or my spouse's credit history

I understand that my application will be denied if it is incomplete or I fail to provide the required documentation.

Signature of Patient or Guardian:_____ Date:_____

Relationship to Patient:_____

Signature of Spouse (if applicable):_____ Date:_____

Please do not write below this line -for office use only

Date Application Received:_____ Received by (Employee Initials):_____

Date of Service:_____ Account#: Amount of Service:_____

Date of Service:_____Account#:_____. Amount of Service:_____

Date of Service:_____ Account #:._____--"Amount of Service:_____

Date of Service:_____ Account #:_____. Amount of Service:_____

Date of Service:_____ Account #:_____--"Amount of Service:_____

Income Verified: _Yes _No Total Amount of Charges:_____

Total Household Size___ _ Total Household Income:_____ ___ Monthly ___Yearly

Application Approved: _____% write-off 100% write-off Patient Class: _ Self Pay _Insurance _Medicare

Application Denied: Household income over limits _ Incomplete Application Other:_____

Notification Letter Mailed:_____ Employee Signature:_____

Reconsideration Results:_____ Notification Mailed:_____