Financial Assistance Check list

Name of Applicant:_____ **Date:**_____

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

_____ You will need to provide **three** months' worth of your entire bank statement. Please do not line out any items on the statements.

_____ 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 Letter of Support is required from the person who provides Room and board for you and your family. A letter of circumstance is required from the applicant of why you have no income.

_____ 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.

_____ Photo ID and Social Security Card

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.

Clinch Memorial Hospital
Patient Financial Services
P.O. Box 516, Homerville, GA 31634 | 912-470-2410

Clinch Memorial HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

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

Account Number	Marital Status (check one)	Home Telephone #
	☐ Married ☐ Single ☐ Divorced ☐ Widowed	

Address	City, State, Zip	Cell/Alternate Phone #

Email Address:

Parent/Guardian Name *(if patient is under 21)*	Phone #	Address	City, State, Zip

Parent or Guardian's 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 (if yes) Check one: ☐ Medicaid ☐ Wellcare ☐ Amerigroup ☐ Peach State

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

Name	Relationship	Age	Disabled
1			☐ No ☐ Yes
2			☐ No ☐ Yes
3			☐ No ☐ Yes
4			☐ No ☐ Yes

If more than 4 in household, please list the remaining members on a separate sheet of paper

ASSETS – Please fill in ***each*** line, write N/A if 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 assets 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 the last four 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):			

Print Name	Signature	Date

Financial Assistance Application

Consent, Authorization, and Attestation:

Please read and print your first and last name on each line below if applicable:

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 _____ certify that I did not file a Federal Income Tax Return for the most recent fiscal year.

I _____ certify that I do not have a checking or savings account.

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 my information may be used to screen for other benefits and if I qualify, I must first apply for those 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.

I _____ understand that the hospital or third party 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.

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

I attest that the above information is true and accurate.

Signature of Patient or Guardian:_____ Date:_____

Relationship to Patient:_____

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

Clinch Memorial HOSPITAL

LETTER OF SUPPORT

Account #: _____

For the Guarantor:

I, _____, certify I have no income and that
(Guarantor Name)
_____ is
(Supporter)
currently providing for my everyday means of support. I have provided to the hospital all information regarding any insurance or third-party payer coverage or any type of reimbursement that the patient or I may have or may be eligible for. I also confirm that I am not receiving food stamps or any other type of assistance. If our household does receive food stamps or any other type of assistance, I will provide proof of that assistance attached to this letter.

I hereby certify that all information given is to the best of my knowledge true and correct.

Signature of Guarantor:_____Date:_____

Relationship to Patient: _____

For the Supporter:

I, _____, have been providing the everyday means of
(Supporter)
support
for _____ since _____ for the reason this
(Guarantor) (Date)
individual receives no income or assistance of any type. I understand that if I receive food stamps or if the patient requesting help receives food stamps, then we must provide proof of that assistance. I hereby certify that
the information given is to the best of my knowledge true and correct.

I understand that by signing this document I am not being held liable for the patient bill.

Signature of Supporter: _____Date: _____

Relationship to Patient: _____ (may not be spouse)

Questions regarding this form may be directed to the Financial Assistance Counselor at (912) 487-5211 Ext. 2410.