# Financial Assistance Application

## I. Patient Demographics

**Patient Name:** _____

**DOB:** **SSN:** **CI/MRN:** /

**Guarantor Name:** **DOB:** **SSN:**

**Street Address:** **Phone:**

**City:** **State:** **Zip:**

Have you applied for Financial Assistance with any Healthcare facility in the past? _____ Yes _____ No.

If yes, name of facility _____ date of application or approval? _____

## II. Household Information

| Marital Status (Circle One) | Married | Single | Separated | Total in Household |
|---|---|---|---|---|

| Dependent Name(s) | Dependent Date of Birth |
|---|---|
| | |
| | |

## III. Employment/Income

| |
|---|
| Patient/Guarantor Employer: |
| Gross Monthly Income Amount $ |
| Income Source-*Please attach verification or explanation of current situation* |
| Spouse or other Income Source and Gross Monthly Amount $ |
| Total Annual Gross Household Income $ |
| Do you have an active bank account? Did you file taxes for the prior year? |

## IV. Insurance Verification

| | | |
|---|---|---|
| Do you have any health insurance? | YES | NO |
| Name of Insurance Company: | | |
| Are you employed? | YES | NO |
| If you have become unemployed within the last 90 days, please provide:<br><br>The name of your last employer and dates of employment:<br><br>Give the name of your employer sponsored insurance carrier:<br><br>Are you eligible for COBRA Benefits? | | |

*I certify that the information provided is true and to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I authorize the release of any information needed to verify the information provided and for billing and collections in compliance with applicable federal and state laws. Proof of income may be required before any consideration is made. Acceptable proof of income maybe but not limited to: copy of paycheck stubs, copy of last year's tax return, or letter from employer stating present salary and hours worked.*

| |
|---|
| Signature of Patient/Guarantor: Date: |

| | | | | |
|---|---|---|---|---|
| % Federal Poverty Level: | | Decision Based On: | | |
| Comments/Summary: | | | | |
| Signature of Interviewer | | Date: | | |
| Signature of Manager | | Date: | Approved | Denied |
| Signature of Director | | Date: | Approved | Denied |
| Signature of VP(if applicable) | | Date: | Approved | Denied |

Mail completed application to PO Box 934805, Site ID 2200, Atlanta, GA 31193
Fax to 678-486-6036 or email the application and required documents to charitycare@patientfinancialsvcs.com