
# Financial Assistance Application

***Need assistance call 819-2434 or 819-8246***

Patient's Name_____ MRN #_____ Date _____

********IMPORTANT********

In order for a Financial Assistance request to be processed, the following financial information MUST be returned with this completed and signed application. If you cannot provide the following please explain: (I certify that the information provided is true & complete)

☐ Most recent pay stubs or Supplemental Security Income (SSI provided by Social Security)

☐ Most recent statements from checking, savings, certificates of deposit, stocks, bonds, money market etc.

☐ Most recent Federal Income tax forms including schedules C, D, E & F

☐ Most recent W2 statement or 1099

Do you own your Home ☐ Yes ☐ No Estimate value_____Monthly Mortgage/rent_____

Guarantor Name:_____Relationship to Patient_____SS#_____
(head of household)

Spouse's name if Married_____SS#_____Phone#_____

Street Address:_____City_____State_____Zip Code_____

How many Dependents live in household?_____Please list total family members in household_____

List monthly Income:

Employment:_____SSI_____Alimony/Child support_____Pension_____

Trust fund_____Public Assistance_____Investment Income_____Rental income_____

I certify that the information provided is true and accurate. I hereby grant permission and authorize any agent of the Georgia Dept. of Community Health to disclose to the hospital all information regarding the status of my Medicaid application; and if such application is not approved, the reason for disapproval.

Signature of Applicant_____Date_____

**For St. Joseph/Candler Use Only**

Adjustment totals_____Adjustment code_____Financial Assistance Category_____

Approvals: Director_____Date_____

VP of Revenue Cycle:_____Date_____

CFO:_____Date_____

CEO:_____Date_____

Percentage of Federal Poverty Guidelines is_____Approved if below_____of Federal Poverty Guidelines