**FINANCIAL ASSISTANCE APPLICATION**

Our records indicate that you have an outstanding balance with Morehouse General Hospital. You may qualify for our Financial Assistance Program. This program would reduce your bill based on your household income and household size. Applicants may qualify for a reduction of anywhere between 20% up to 100% reduction. You have 30 days to return.

**Items Needed:**

Identification (Driver’s License or other picture ID)

Last 3 months proof of all income/paystubs

Last 3 months of checking and/or savings account

Tax Returns

Copies of House Hold Bills: light, water/sewer, gas, car payment, telephone etc.

**Please complete the attached application and provide the required information so that we can assist you promptly.**

**Please contact Andrea Morgan @ (318)-283-3680 to make an appointment, or mail application with supporting documents to the address above.**

***Financial Assistance Application***

**Patient Account Number(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| ***COMPLETE THE APPLICATION IN FULL AND SIGN.*** |
| **Patient Information** |
| Last Name:  | First:  | M.I. |
| Date of Birth | SSI - -  | Family Size: |
| Street  |
| City | State | Zip Code |
| Home Phone | Cell Phone | Work Phone |
| Employer Name | Address | Phone# |
| Monthly Income(before taxes) |
| **Spouse Name:** | Date of Birth | SSI# - -  |
| Address | Phone# |
| Employer Address | Work Phone# |
| Monthly Income(before taxes) |
| Family Members1. | Age | Date of Birth | Relationship to Patient | Income for 3Mths prior to Date of Service |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |

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| ***Office Use Only:******Total yearly income\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_******Federal Poverty Guidelines for a household size of \_\_\_\_\_\_\_\_\_ people \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.*** |

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| Does anyone in the household receive income from any of the following**Supply Copies of Supporting Documents** |
| Yearly Gross Wage Income: | $ | CD’s, IRA, Stocks, Bonds: | $ |
| Alimony/Child Support: | $ | Interest or Dividends: | $ |
| Social Security Income: | $ | Life Insurance Proceeds: | $ |
| SSI Income: | $ | Savings Account: | $ |
| Worker’s Compensation: | $ | Checking Account: | $ |
| Retirement/Pension: | $ | Cash on hand: | $ |
| Unemployment Income: | $ | Food Stamps: | $ |
| Real Estate other then homestead: | $ | Any other Income: | $ |
| Please provide one or more of the following for each employed family member or sign the statement below.1. A copy of most recent tax returns
2. A copy of most recent W-2 and 1099 Forms
3. A copy of most recent 3 pay stubs

If you cannot provide any documentation relating to your income, or if you reported **$0.00 income** please provide a brief explanation of how you (or the patient) survived financially during the period requested for charity, **and**  **fill out the statement below:** |
| **Household Monthly Expenses**  | **Who Pays these Expenses** |
| Do you Rent or Own your home?  |  |
| House Rental/Payment:  | $ |  |
| Home Owners Insurance | $ |  |
| Food | $ |  |
| Car Payment | $ |  |
| Car Insurance | $ |  |
| Electric | $ |  |
| Gas | $ |  |
| Water/Sewer | $ |  |
| Phone Bill | $ |  |
| I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ certify that I have no documents to prove my family’s income of $\_\_\_\_\_\_\_\_\_\_\_\_ or $0.00 income  |

**By my signature below, I affirm to the best of my knowledge that the answers on this application are true. I understand that it is unlawful to knowingly submit false information to obtain benefits. I further understand and agree that if the above information is untrue, any financial assistance granted to me will be voided, future requests may be denied, and I will be responsible for the payment of the hospital bill.**

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| **FOR HOSPITAL USE ONLY**Financial Counselor Submitting Application:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Financial Counselor Accepting Application:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_APPROVED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DENIED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (VOID 9 MTHS FROM APPROVAL DATE)INCOMPLETE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Approved By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Application must be approved by Director of Patient Financial Services or Authorized Personnel** |

**Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**