

FINANCIAL ASSISTANCE APPLICATION

Patient's Name _____ CPI # _____ Date: _____

Name of Applicant: _____ - _____ Relationship to Patient _____

Address: _____ City: _____ State: _____ Zip : _____

Telephone _____

Is your visit related to an accident or injury? _____ If yes, what type? _____

List members of household, birthdate, relationship and income from each source; state whether income is week, month or year:

NAME	BIRTHDATE	RELATIONSHIP	GROSS INCOME (wk/mo/yr)

Do you receive SNAP/food stamps? Y N

The documents listed below are required, if applicable (see reverse for instructions). Please include them with your application.

Copy of most recent pay stub(s) with annual total(s) for all family members listed above.

Copy of most recent Federal Income Tax Return, including all schedules.

Proof of any income listed as other income.

I certify that all the above information is true, complete and to the best of my knowledge. I authorize the release of information needed to determine whether I qualify for financial assistance or other Federal or State funded program, including verification of my income and assets. I hereby grant permission and authorize an agent of the Georgia Department of Community Health to disclose all information regarding my Medicaid application.

I understand that information, which I submit, is subject to verification, including credit reporting agencies, and others as required or necessary.

Signature of Applicant

Date



FINANCIAL ASSISTANCE APPLICATION

Augusta University Health System offers a financial assistance programs for patients and families experiencing financial difficulty and are unable to pay their hospital bill. For those who qualify, financial assistance discounts may help with medically necessary services. Simply complete the Financial Assistance Application, attach copies of documents to verify your income and return it to any of the following:

By Mail:
Augusta University Health
Attn: Financial Counseling Department
1120 15th Street BI 1010
Augusta, GA 30912

By Fax:
(706)721-4848

For Questions:
Call Financial Counseling
(706)721-1301

Please include the following documents with your Financial Assistance Application:

Provide a copy of their most recent completed, signed Federal Income Tax 1040A, 1040EZ or 1040 with tax schedules

Copy of pay stubs for the most recent past three (3) months with year to date totals for all members of the family working.

If the patient (or responsible party) did not file taxes the last year or if the income situation has changed, the patient should provide photocopies of at least one of the following documents to verify total family gross (before deductions) income:

Copy or statement showing alimony, child support, rental income, interest, dividends, regular support payments, income from estates or trusts

A dated and signed letter from employer on company letterhead stationary stating the amount of gross income per day period and total number of hours worked per pay period

Copy of checks or statement showing pensions, Social Security, Veterans Benefits, Public Assistance. *Temporary Assistance Needy Families (TANF) or Social Security Insurance (SSI) income received by any family members are excluded and will not be included in the calculation of total family gross income.

Copy of bank statement showing an “electronic deposit” from the federal government of Social Security, Veterans Benefits

Statement showing Worker’s Compensation or Unemployment

Copy of Food Stamps Summary

Letter from Department of Family and Children Services or Social Security Office verifying income

Please promptly return your income verification documentation in order to complete your financial assistance application. If you do not complete the financial assistance process, you will be billed for outstanding hospital balances. If you have any questions, please contact our Financial Counseling Department at (706) 721-1301. Send documentation to: Financial Counseling Department 1120 15 St., BI 1010 Augusta GA 30912.