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)

Total monthly income minus total expenses: $ _____
Do you own your home? Y ☐ N ☐ If yes, what is the estimated value? $_____
Do you own other real estate? Y ☐ N ☐ If yes, what is the estimated value? $_____
Do you receive SNAP/food stamps? Y ☐ N ☐
Do you own other assets listed below ?☐Y ☐N If yes, please list below.

Automobiles			Checking/Savings/Investments	
Make	Yr	Value $	Bank	Value $
Make	Yr	Value $	Bank	Value $
Make	Yr	Value $	Other	Value $

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

Form: FAP Revised 08/28/2019

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: Patient Accounting Department
1120 15th Street HS 1331
Augusta, GA 30912

By Fax:
(706)721-9097

For Questions:
Call Customer Service
(706)721-2961

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 Customer Service Department at (706) 721-2961.
Send documentation to: Patient Accounting Department 1120 15 St., HS 1331 Augusta GA 30912.