



FINANCIAL ASSISTANCE APPLICATION

Augusta University Health System offers a financial assistance program for patients and families who are experiencing financial difficulties and are unable to pay their hospital bill. For those who qualify, financial assistance discounts may help with medically necessary services. Please complete the Financial Assistance Application, attach copies of the documents requested and return 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:

Contact Financial Counseling
(706) 721-1301

Please include the following documents with your completed Financial Assistance Application:

1. Proof of Residency in Georgia or South Carolina
 - a. Driver's License or other identification issued by the State of Georgia or South Carolina; or
 - b. Utility Bill showing street address (not a PO Box) and applicant's name
2. Proof of Income
 - a. A copy of most recently completed and signed Federal Income Tax 1040A, 1040EX, or 1040 with tax schedules
 - b. A copy of pay stubs for the past three (3) months with year-to-date totals for all working family members

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

- c. A copy of or statement showing alimony, child support, rental income, interest, dividends, regular support payments, income from estates or trusts
- d. A dated and signed letter from employer on company letterhead stating amount of gross income per pay period and total number of hours worked per pay period
- e. Copy of checks or statement showing pensions, Social Security, Veteran's Benefits, or 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
- f. Copy of bank statement showing an "electronic deposit" from the federal government of Social Security or Veteran's Benefits
- g. Statement showing Worker's Compensation or Unemployment
- h. Copy of Food Stamps Summary
- i. Letter from Department of Family and Children Services or Social Security Office verifying income

If patient (or responsible party) has no income or other means of support, please provide the following:

- j. Notarized Letter of Support from person(s) or entity providing your primary source of support for necessary living expenses
3. Proof of Expenses
 - a. Copies of rent/mortgage, health insurance, medical bills/pharmacy report, and childcare. Please attach proof/copies of expenses listed above. Do not include any items which are deducted from your paycheck

Your application will not be considered if incomplete or without the accompanying documentation.

MRN: _____

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Patient/Guarantor Name: _____	Date of Birth: _____
Spouse/Partner Name: _____	Date of Birth: _____
Address: _____ _____	Phone: _____
City/ST/ZIP: _____	OK to leave message? Y / N
Email Address: _____	Alt Phone: _____
	OK to leave message? Y / N

Is your visit related to an accident or injury? Y / N If yes (circle one), was it Motor Vehicle or Work Related?

List each member of household, their birthdate, relationship, and any income received and include frequency. If more space is needed, please use a separate sheet of paper.

Name	Birthdate	Relationship	Gross Income (wk./mo./yr.)
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$

Please list any other sources of income and monthly amount	
Alimony/Child Support	\$
Social Security/Pension	\$
Public Assistance/Food Stamps	\$
Unemployment/Worker's Comp	\$
Other Sources (specify):	\$

Please list monthly expenses and amounts (This information helps to identify all available resources for assistance)	
Rent or Mortgage (Primary and Secondary)	\$
Utilities Standard Deduction (Electric/Gas/Water)	\$
Health Insurance/Life Insurance	\$
Medical Bills (Non-AU)/Pharmacy	\$
Child Care/Adult Care	\$
Government Tax Payments	\$

I certify 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 programs, 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