



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