Northeast Georgia Health System
Improving the health of our community in all we do

FINANCIAL ASSISTANCE APPLICATION

MRN/Patient Number: _____

Part 1: Applicant's Information Date: _____

Patient Name: _____ Date of Birth: _____

Applicant's Name (if different from the patient): _____

Phone Number: (home) _____(cell) _____

Address: _____

Street City Zip

Part 2: What is the reason the patient is applying for Financial Assistance?

Where will you / have you received care? ❑ Hospital ❑ THC Office

1. I am applying for a scheduled service or my doctor asked to be scheduled.
   - ❑ Yes
     Who referred you for the service (doctor/other): _____
     Type of service: _____
     Date of scheduled service: _____--or--
     Doctor's requested timeframe: _____
   - ❑ No
2. I am applying because I have existing bills that I cannot pay.
   - ❑ Yes
     Please list the account number(s):
     _____
   - ❑ Yes, but do not know account numbers
   - ❑ No

Part 3: Please answer the following questions from the patient's perspective:

1. How old are you? _____
2. What is your marital status? ❑ Single ❑ Married ❑ Divorced ❑ Widowed
3. Are you currently employed? ❑ Yes ❑ No
   Name and address of employer: _____
4. If you are not currently employed, have you been employed in the last 90 days? ❑ Yes ❑ No
   Name and address of employer: _____
5. Do you have any insurance, including Medicare or Medicaid, that will be paying for services?
   ❑ Yes ❑ No
   Name of Insurance: _____
   Policy Number: _____
6. Is anyone else responsible for a portion of your bill (e.g., liability, auto insurance, worker's comp)?
   ❑ Yes ❑ No
   Company: _____
   Claim Number: _____
   Adjuster Name and Phone Number: _____

Patient's Name: _____ Date of Birth: _____

7. Have you applied for Disability? ❑ Yes ❑ No
8. Have you applied for Medicaid recently? ❑ Yes, denied coverage ❑ Yes, it is still pending ❑ No
9. Are you pregnant or have you given birth within the last 90 days? ❑ Yes ❑ No
10. Is the service(s) you are applying for related to cancer? ❑ Yes ❑ No
11. Is the service(s) you are applying for from an inpatient visit? ❑ Yes ❑ No
12. Is the service(s) you are applying for related to care for being a crime victim? ❑ Yes ❑ No
13. Do you have any insurance coverage? ❑ Yes ❑ No
    Please list insurance coverage the applicant has: _____

Part 4: Household Information

1. Are you a US citizen? ❑ Yes ❑ No
2. In which county do you live? _____
3. How many people live in your home? _____
4. What is your total gross monthly household income (including alimony, child support or any other income received, monthly)? _____
5. Do you own a home? ❑ Yes ❑ No
   Value _____ Equity _____
6. Please list your banking account balances: Savings _____ Checking _____
   Retirement Accts (IRA, 401k, 403b)_____ CD's_____ Other _____

Patient:

Name	Date of Birth	Sex	Social Security Number	Employer	Gross Monthly Income

Dependents (individuals claimed as dependents on your tax return):

Name	Date of Birth	Sex	Relationship to Patient	Social Security Number	Employer	Gross Monthly Income	Has Existing Bill

By completing this application you agree:

- To apply for Medicaid and/or any other type of potential coverage available to pay for your care.
- That all of the information provided is accurate and complete and will be verified. Providing false information will result in a denial of financial assistance. Additionally, NGHS/THC reserves the right to reverse financial assistance if information is found to be false.
- To provide all information within 30 days of submitting an application.

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I understand that NGHS/THC may obtain my credit history and that of any adult in the household. I hereby certify that the information I have provided is accurate and complete.

_____ _____

Applicant's Signature Date