SOUTHEAST GEORGIA HEALTH SYSTEM
APPLICATION FOR FINANCIAL ASSISTANCE

1. Applicant / Patient Information:

Name: ____ Home Phone: __________________________

Address: ____ Date of Birth: __________________________

City, State, Zip: ______________________________________ Soc Security #: _______ - _____ - _______

County: ____ Do you have Health Insurance ☐ Yes ☐ No

Have you previously qualified for assistance from other health care providers? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Insurance Information: _______________________________ **Attach a copy of the insurance card**

2. Co-Applicant / Spouse / Guarantor Information:

Name: ____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other

Social Security Number: _______ - _____ - _______

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Guarantor's Date of Birth: _____________________

Home Phone Number: _______________ Employer's Name: __________________________ Work Phone: ___________________

3. Dependents / Household Members:

(List the names of all members in your household and family and their relationship to you. Please check the box (☐) if you claim him/her on tax return form). **If you list any children on your application that are not biological or stepchildren, you must provide legal documentation to this effect.**

Full Name	Relationship to Patient	Date of Birth	Social Security #
☐		/ /	
☐		/ /	
☐		/ /	
☐		/ /	
☐		/ /	

4. Employer Information:

Patient's Employer:

☐ Employed ☐ Homemaker ☐ Retired
☐ Unemployed ☐ Disabled

Employer's Name: ________________________________

Address: ______________________________________

Job Title: ______________________________________

Length of Employment: ____________________________

Weekly hours worked: _______ Annual Income: $______

How are you paid? ☐ Weekly ☐ Bi-Weekly ☐ Month ☐ Other

Spouse's / Other Household Member's Employer:

☐ Employed ☐ Homemaker ☐ Retired
☐ Unemployed ☐ Disabled

Employer's Name: ________________________________

Address: ______________________________________

Job Title: ______________________________________

Length of Employment: ____________________________

Weekly hours worked: _______ Annual Income: $______

How are you paid? ☐ Weekly ☐ Bi-Weekly ☐ Month ☐ Other

Household Income: Defined as income of all individuals who live together and typically purchase and prepare meals together. List the amount of your monthly income from all sources. If a family member or someone other than a family member provides more than 50 percent support for living expenses, please provide monthly income for the supporting individual.

Please provide a copy of documentation to support each income and asset source listed.

5. Monthly Household Income Information: Give monthly income for yourself and other household members.

	Patient	Spouse	Proof Needed
Wages (including tips)			Pay stubs and most recent Federal Income Tax 1040
Business Income			Income Statement, Schedule C/E from Federal Taxes
Social Security benefits (SSA/SSI) / Disability			Benefit Statement for all who receive
Retirement / pension benefits			Benefit Statement
Public Assistance benefits (food stamps)			Budget Worksheet
Veterans benefits			Benefit Statement
Unemployment benefits			Benefit Statement
Rental Property Income (Does anyone pay you rent?)			Income Statement, Schedule C/E from Federal Taxes
Workers' Compensation			Statement
Alimony or Child Support Payments Received			Court order stating amount
Other Income: ________________________			
Total Monthly Gross Income:	$		

Unemployment: If you do not have income, please explain how you take care of your monthly living expenses. You may be asked to furnish a letter from the Department of Labor regarding your unemployment status.

6. Monthly Expenses: Give information about the bills you pay every month.

Monthly Expenses	Monthly Payment	Monthly Expenses	Monthly Payment
Rent/Mortgage Payment		Credit Cards (minimum payment)	
Utilities		Child Support	
Food		Spousal Support/Alimony	
Cable		Child Care	
Auto Loan(s)		Liens / Wage Garnishments	
Auto Insurance		Medical Bills	
Loans		Other:	
Total Monthly Expenses:	$		

Total Monthly Income (Section 5)	
Total Monthly Expenses (Section 6)	
Total Monthly Income – Total Monthly Expenses	**$**

7. Bank Account Balances: Attach copies of your account statements.

	Patient	Spouse	Financial Institution
Checking Account Balance			
Savings Account Balance			
Stocks, bonds, CD or money market Balance			
Other accounts: ____________________________			
Total Bank Accounts:	$		

8. **Assets / Property**: Include all property and assets that you own, including all recreation vehicles, etc.

Type	**Detail**	**Estimated Value (A)**	**Unpaid Balance (B)**
Residence			
Vehicle #1	Type/Year/Make		
Vehicle #2	Type/Year/Make		
Vehicle #3	Type/Year/Make		
Land	Number of Acres		
Rental Property			
Business			
Other			
A. Total EstimatedValue			
B. Total Unpaid Balance			
Estimated Value (A) – Loan Balance (B)	$		

9. **Additional Information:** Provide information regarding the medical service in which you need assistance.

I am applying for a scheduled service.

☐ **Yes** ☐ **No**

If yes:

Who referred you for the service (doctor/other): ________________________

Type of medical service: ____

Date of scheduled medical service: ___________________________________--or--

Doctor's requested timeframe: ____

I am applying because I have existing bills that I cannot pay.

☐ **Yes** ☐ **No**

Please list the account number(s): ____

Medicaid Application Status:

Have you applied for Georgia Medicaid?

☐ Yes-Awaiting Approval ☐ Yes-Not Eligible ☐ No (if you indicated no, please check all that apply to you below)

- ☐ I am currently pregnant
- ☐ I am the parent or relative caretaker of dependent children under 19 years of age
- ☐ I am 65 years of age or older
- ☐ I am blind
- ☐ Myself, or someone within my household, has a disability

Note: *If you have applied for Medicaid and have not received a final determination, please contact your caseworker.*

Please Read the Following Before Signing and Dating the Application

Please be advised that your signature indicates that you have agreed to attach all income verification and other requested supporting documentation. In addition to the items requested by this application, you may attach bank statements, copies of social security checks (or letters). If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient of the spouse is self-employed, please attach the last 2-3 months of bank statements. Additional information may be requested by the financial advocate. All documentation must be attached for full consideration.

Certification

1. **I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.**
2. **I will apply for any and all assistance that may be available to help pay this bill.**
3. **I understand the information submitted is subject to verification; therefore, I grant the permission and authorize any bank, insurance company, real estate company, financial institution and credit grantors of any kind to disclose to SOUTHEAST GEORGIA HEALTH SYSTEM all pertinent information regarding past and present accounts.**
4. **I understand that financial assistance will not be granted if complete and accurate information and supporting documentation are not provided.**

I, ____________________ , give permission to Southeast Georgia Health System to share information contained in this application and supporting documentation with Cooperative Healthcare Services, Inc.

____ ______________________________

Signature Patient/Guardian Date

____ ______________________________

Signature Spouse Date

Please return completed application and required documentation to:

Southeast Georgia Health System
Attention: Financial Assistance Department
P. O. Box 1518
Brunswick, Georgia 31521
(912) 466-5000

SOUTHEAST GEORGIA HEALTH SYSTEM
Supporting Documentation Requirements

Financial Assistance may only be granted based on the receipt of a **completed and signed** Financial Assistance application along with the following documentation requirements: (*Please Provide* ***Copies Only***)

<table>
<tr><td colspan="8">Step 1) Verification of Identification (1 document required) – <u>Copy Only</u></td></tr>
<tr><td>☐</td><td>Georgia Driver's License</td><td>☐</td><td>Georgia State ID Card</td><td>☐</td><td>College/Student ID</td><td>☐</td><td>Permanent Resident Card (Green Card)</td></tr>
<tr><td colspan="8">Step 2) Verification of Residency – For applicants that do not have a current driver's license or state ID (1 document required) – <u>Copy Only</u></td></tr>
<tr><td>☐</td><td>Voter Registration Card</td><td>☐</td><td>Utility Bill with Complete Name and Address</td><td>☐</td><td>Property Tax Bill</td><td>☐</td><td>Mortgage Lease or Statement</td></tr>
<tr><td colspan="8">Step 3) Proof of Income – Provide documentation to support each income amount listed on application: <u>Copies Only</u>.
Note: We may require more than one document to confirm income.</td></tr>
<tr><td>☐</td><td>Pay Stubs: Lat Month: (4-Weekly, 2-Biweekly, 1-Monthly)</td><td>☐</td><td>Current Tax Return / W-2</td><td>☐</td><td>W-2 from Most Recent Tax Filing (If no taxes are available</td><td>☐</td><td>Employer Notarized Letter Confirming Monthly Income Amount</td></tr>
<tr><td>☐</td><td>Alimony and /or Child Support Documentation</td><td>☐</td><td>Social Security SSDI) Award Letter</td><td>☐</td><td>Social Security – Bank Statement Showing Auto Deposit</td><td>☐</td><td>Unemployment Benefits 1099 Award Letter</td></tr>
<tr><td>☐</td><td>Food Stamps Award Letter</td><td>☐</td><td>Cash Assistance Award Letter</td><td>☐</td><td>Notarized Court Letter Stating Income</td><td>☐</td><td>*Support Notarized Letter Stating Assistance to Patient</td></tr>
<tr><td>☐</td><td>Self Employed – Income Statement</td><td>☐</td><td colspan="5">Self Employed – Most Recent Tax Return – All Pages: (Last Year) Including but not limited to Self Employment Earnings (Schedule C from Tax Return), Schedule E from Taxes (Rental Schedule)</td></tr>
<tr><td colspan="8">Step 4) Verification of Assets – Provide documentation to support each asset amount listed on application: <u>Copies Only</u>.
Note: We may require more than one document to confirm assets.</td></tr>
<tr><td>☐</td><td>Checking Account Last 2 months</td><td>☐</td><td>Savings Account Last 2 months</td><td>☐</td><td>Mortgage Statement</td><td>☐</td><td>Stocks Statement</td></tr>
<tr><td>☐</td><td>Bonds Statement</td><td>☐</td><td>Certificate of Deposit Statement (CD)</td><td>☐</td><td>Money Market Statement</td><td>☐</td><td>Reverse Mortgage Benefit Statement</td></tr>
<tr><td>☐</td><td>Vehicle - Proof of Ownership</td><td>☐</td><td colspan="5">Other</td></tr>
</table>

*If someone other than your spouse is providing you more than 50 percent support for living expenses, please provide the above documentation for the supporting individual.