COFFEE REGIONAL MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

You may be eligible for financial assistance under the Federal Poverty Income Guidelines. Please complete this application and return it with the requested documentation listed below.

Provide ALL income verification listed below that applies to your Family Unit. (applicant/patient, spouse/significant other, and legal dependents).

____ **Wages**: Check stubs or statement from your employer indicating the last three (3) checks showing the gross income.

____ **Self-Employed:** If you and/or your spouse are self-employed, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.

____ **Unemployed:** Department of Labor Wage Inquiry from your local Department of Labor. Picture identification will be required.

____ **Social Security:** Social security eligibility letter or a copy of your social security check. (If you have direct deposit, we will need a copy of your bank statement showing verification of this income.)

____ **Tax Returns:** Previous year's income tax return, or _____.

____ **Other Income:** Proof of any other income source such as child support, alimony, trust funds, or rental property.

____ **No Income:** If you have not had any income for the last three (3) months, please send:

____ A statement from the person(s) providing food and shelter.

____ **Other:** _____

Failure to submit the requested information may result in denial of your application because your financial eligibility could not be determined. This application is valid for 180 days from your request for Financial Assistance.

Approval under the Financial Assistance Program is effective for charges incurred from Coffee Regional Medical Center only. The program does not cover physician charges such as Pathology, Cardiology, Radiology, private physicians, or medication.

Return application and income proof to: **OR**

Coffee Regional Medical Center
Patient Financial Services (PFS)
196 Westside Drive
Douglas, GA 31533

Mail the application and income proof to: **OR**

Coffee Regional Medical Center
Patient Financial Services (PFS)
Attn: Financial Counseling
P O Box 1227
Douglas, GA 31534

Fax to:

912-383-6917
Financial Counseling

NOTE: Financial assistance will not be considered without income proof *and* the completed application signed.

FINANCIAL ASSISTANCE APPLICATION

COFFEE REGIONAL MEDICAL CENTER

Applicant/Patient:_____ Social Security #:_____-_____-_____

Mailing Address:_____ City/State:_____ Zip:_____

Street Address:_____ City/State:_____ Zip:_____

Home Phone #: ( )_____-_____ Cell Phone # ( )_____-_____

List Members of Family Unit: (defined as applicant, spouse, and all legal dependents as allowed by the Federal Government)

Family Member Name	Birth Date	Gender	Relationship to Patient	Social Security Number	Employed (Yes / No)	Gross Monthly Income
			SELF			

Other income source(s) that you receive monthly:

SSI (Supplemental Security Income) $_____
SSDI (Social Security Disability) $_____
Unemployment $_____
Food Stamps $_____
Welfare (AFDC) $_____
(VA) Veteran's Benefits $_____
Pensions/Retirement Benefits $_____
Child Support $_____
Interest/Dividends On Investments $_____
Other Income: $_____

Assets:

Savings Accounts(s) $_____
Checking Account(s) $_____
Stocks/Bonds (market value) $_____
Certificate of Deposit(s) $_____
Recreational Vehicles $_____
Cars/Trucks $_____
Other Assets: $_____

Monthly Household Living Expenses:

MORTGAGE/RENT:
Mortgage/rent monthly payment $_____
Property taxes/insurance
Appraisal value of home $_____
UTILITIES: (water, garbage, electric, gas gas, cable, and phone/cell) $_____
Groceries $_____
TOTAL AUTOMOBILE PAYMENTS:
1st Automobile payment $_____
2nd Automobile payment $_____
CREDIT CARDS: $_____
LOANS: $_____
INSURANCE PREMIUMS:
Life $_____
Medical $_____
HEALTHCARE EXPENSES:
Medical Bills $_____
Dental Bills $_____
Prescriptions $_____
CHILD CARE EXPENSES: $_____
OTHER EXPENSES: $_____

If you have not listed income, please explain how you are paying for food and housing:

_____

Please turn to back of this page. ▶

COFFEE REGIONAL
MEDICAL CENTER

196 Westside Drive
P.O. Box 1227
Douglas, GA 31534-1227
(912) 384-1900
FAX: (912) 383-6917

DISCLAIMER

By signing below, I agree that I have read and understand the following as it relates to my application for the Financial Assistance Program (FAP) at Coffee Regional Medical Center (CRMC).

* Incomplete applications and/or documentation of income will result in a denial of my application.
* Financial Assistance will only cover bills for CRMC charges.
* It is my responsibility to immediately notify CRMC Financial Counseling or Patient Financial Services of any additional services provided within thirty (30) days from the date of this application.
* The billing process will continue on my total balance due until notification of approval.

The information given is true and correct to the best of my knowledge. I understand that any false statements given by me to receive assistance to which I am not entitled may disqualify me from this program and any funds utilized through this program will be voided.

Information provided will be used for the purpose of evaluating my financial condition and ability to pay any bills or charges for hosptial services that I have received from Coffee Regional Medical Center or any accounts which I have signed as Guarantor. I authorize my employer to release information regarding my income which may be necessary in evaluating my financial needs. I agree to promptly notify Coffee Regional Medical Center of any changes in my financial status affecting my ability to pay. By requesting financial assistance, I understand Coffee Regional Medical Center may inquire into my credit history.

Signature of Applicant: _____

Date: _____

Do Not Write Below This Line. For Hospital Staff Use Only

Summary and Analysis Description

1. Annual Family Income $_____ Approved Date _____
2. Number in Household _____ Denied Date _____
3. % of Charity Allowed _____ ***(Does not meet financial guidelines)***
4. Adjustment Code _____ Medicare (___) Yes

( ) Initial App FAP Staff Signature:_____ Date Notice Mailed:_____

( ) Re-Validation {after 90 days of initial application} ( ) Re-Consideration

( ) In person ( ) On phone ( ) Changes **Notate on 1st page of application**

PFS Staff Signature:_____ Re-Validation Date :_____ *Send to FAP.

FAP Staff Signature: _____ Approved Date _____

% of Charity Allowed _____ Denied Date _____

Adjustment Code _____ ***(Does not meet financial guidelines)***

Pending: _____

Request Date: _____ ( ) In person ( ) On phone ( ) By letter Staff Initials _____