FINANCIAL ASSESSMENT APPLICATION

PATIENT NAME: ____

ACCT#: ____

TODAY'S DATE:____________________APPLICATION DUE:_____________________

Return all documentation that applies to all members of your <u>HOUSEHOLD:</u>

_____ Signed Acknowledgement of Charity Disclaimer

_____ Social Security Card with correct name and/or current Alabama driver's License.

_____ Most recent year's Income Tax Return (completed return-we do not accept W2 only) for all members of the household. If you did not file not a tax return, we will need a T4506-T form.

_____ Food Stamp monthly allotment verification. The letter can be picked up at the Food Stamp Office.

_____ Proof of unemployment benefits, which must have the maximum benefits listed.

_____ Social Security/SSI Original Award letter, if applicable.

_____ Proof of Social Security/Disability Income, if applicable.

_____ Proof of Child Support and/or Alimony received.

_____ Most recent bank statement.

_____ Proof of any other sources of support being provided by family or friends. This must include the approximate dollar amount per month and must be notarized.

_____ Three most recent pay stubs for all household members earning income and/or at notarized statement from the employer if you do not receive paystubs.

_____ Copy of all recent bills reported, such as:

_____ Mortgage/Rent	_____ Home Owners Insurance	_____ Car Payments
_____ Car Insurance	_____ Health & Life Insurance	_____ Medical Bills
_____ Pharmacy Bills	_____ Credit Card Statements	_____ Loan Statements

Return the application and documentation to our office. We will make copies if needed.
If mailing, please send copies only. We will not be responsible for original documents.
Additional documentation may be required depending on individual situations
If you have any questions please contact one of the Counselors at 256-737-2677 or 256-737-2678.

<u>DISCLAIMER: Our determination of approval for assistance is not necessarily taken into consideration by other providers. Please contact other providers directly for information regarding any bills you may have with them.</u>

Updated 08-19-2016

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Patient's Name ____________________________DOB ____/____/____ SSN: ______________

Sex: ____M____F   Martial Status: S M W D

Guarantor's Name_________________________ DOB ___/____/_____ SSN:______________

Sex: ____M____F   Relationship to Patient _________

Current Address____________________________ City __________________State _________

Zip Code _____________ County _________________ Own/Rent ______How Long? ___________

Home Phone # ________________ Cell # __________________Work #__________________

Number of people in the household ______ Number of people who are working ______

Patient's Employer ___________________________________ How Long?________________

Spouse's Employer ___________________________________ How Long?________________

Do either employer(s) offer health insurance? (circle)   Yes   No

Have you recently lost insurance coverage from a former employer? (circle) Yes   No

If yes, is it possible you are eligible under COBRA? (circle) Yes   No

Have you applied for insurance under the Affordable Care Act? (circle)   Yes   No

Cost of Coverage per month: Family $ ___________________ Single $___________________

If unemployed, how long? _____________   Do you receive unemployment check? _________

If spouse unemployed, how long?_________ Do they receive unemployment check?________

Name of Bank __________________________   Do you have?   checking____   savings_____

Do you receive Child support?   Yes   No   Alimony? Yes   No   How much? _____________

Have you ever applied for SSI/Disability?   Yes No When did you last apply? ____________

Is the case? Pending ____ Denied ____   Approved ____

If pending or denied, are you represented by an attorney?   Yes ____ No____

Was this visit accident related? ________   If yes, was liability insurance involved? ________

If yes for liability insurance, provide name/phone number/address/policy information of insurance:____

Requesting assistance for: __________ Prior Service Date __________ Future Service Date

Updated 08-19-2016

Permission to Release Information to the Good Samaritan Health Clinic

If you are uninsured, a resident of Cullman County and between the ages of 19 and 65, you may be eligible for healthcare services through Good Samaritan Health Clinic. Much of the paperwork required to qualify for the hospital's Charity Program is very similar to paperwork needed by the GSC. In an effort to speed up the application process the hospital will, with your permission, provide the GSC with copies of the documentation you have provided us.

I ____________________________ attest that I am a resident of Cullman County and authorize Cullman Regional Medical Center to release financial information I have provided to CRMC as part of my charity application to the Good Samaritan Health Clinic. Any information not to be provided has been designated as such.

Signature _____________________________________ Date ___________________

Print Name: __________________________________

Witnessed By:__________________________________