Hospital Authority of MILLER COUNTY

Dear Patient,

This letter has important information regarding our Financial Assistance Program (FAP). For assistance with your hospital and medical bills provide the items below (basic requirements). During the interview process it may be determined that additional information is required.

Verification of your household income:

- Three current paycheck stubs or verification of wages on a company letterhead
- Social Security checks or a letter from the Social Security Office showing amount, or documentation of amount received from any other pension source
- Last year's tax return
- Three current bank statements for all checking and savings accounts
- Assets statements with equity adjustments (rental property, farm land, second homes, etc.)
- Current CD, 401K, 403B, IRA, and other investment statements
- Current Profit and Loss statement is required for all self-employed applicants

Additional Information:

- All child support received
- Income of all applicable family unit members
- Valid photo ID, REQUIRED

Verification of Residency:

- Utility bill
- Telephone bill
- Rent / mortgage receipt
- If you live with someone, please provide verification of residency (monthly rent statement if applicable) Proofs of residency may be requested to verify six (6) months residency in the State of Georgia

All documentation is required to process your application.

If you have questions, please contact our Financial Assistance Department at (229) 785-3554. ***We are here to help you!***

Thank you for choosing The Hospital Authority of Miller County for your health.

We are an Equal Opportunity Employer and a Provider for Medicare and Medicaid.

APPLICATION FOR
FREE AND REDUCED-CHARGE SERVICES
UNDER THE ICTF PROGRAM
MILLER COUNTY HOSPITAL

Patient Name: ________________________________ **Date(s) of service:** ________________________________

Amount of Charges: $____

Applicant Name: __________________________________ Relationship to Patient: ________________________

Address: ____

Telephone: ____

List members of household, birthdate, relationship to patient, and income from each source: state whether income is per week, month, or year.

NAME	**BIRTHDATE**	**RELATIONSHIP**	**INCOME (WK/MO/YR)**	**INCOME (WK/MO/YR)**	**TOTAL INCOME**

If income of any member is from self-employment, you may give information on business costs so that We can determine actual income to be counted. Write details on the back of this sheet.

(Note to Applicant: You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills, and would not have to be counted or report income.)

Signature of Applicant: ____ Date: _______________________

For Hospital Staff Use:

NUMBER COUNTED IN HOUSEHOLD: _____ TOTAL COUNTABLE INCOME: __________________

(Average monthly income for last year or past 3 months, whichever is more favorable)

Verification of income supplied? Yes ________ No ________

Determination: Eligible for free services ________ Conditional? _________ Pending: ____________________

Eligible for discount _______ (%) ______ Conditional? _________ Pending: _______________

Ineligible _______ Reason: ____

Date notice mailed: _____________ Staff Signature: ____________________________________ Date: __________

Reconsideration: Result: ____Date: _______

Miller County Hospital
Financial Assistance Worksheet

Patient Information:

Name:	
Social Security Number:	
Date of Birth:	
Address:	
Phone Number:	
Employer Name and Address:	
Employment Status:	*Please circle* Full-time Part-time Not applicable
Spouse's Name:	
Spouse's Social Security Number:	
Spouse's Date of Birth:	
Spouse's Employer Name and Address:	
Employment Status:	*Please circle* Full-time Part-time Not applicable

Household Members:

NAME	DOB	RELATIONSHIP	INCOME	GROSS ANNUAL INCOME
1.				
2.				
3.				
4.				
5.				
Total household income:				

Monthly Expenses:	***Amount of monthly expenses:***
Rent / Mortgage	
Auto	
Utilities	
Phone	
Other: 1._____ 2._____ 3._____ 4._____ 5._____	
TOTAL EXPENSES:	

Description of Assets:

Savings Account Amount and Location:	
Checking Account Amount and Location:	
Savings Bonds and Location:	
CD's Amount and Location:	
Retirement Funds:	
Life Insurance Face Value:	
Rental Property:	
Other Assets:	
TOTAL ASSETS:	

Patient / Guarantor Signature:

_____

APPROVED ☐ **DENIED** ☐

_____ _____

Approval Name **Approval Date**