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APPLICATION FOR FINANCIAL ASSISTANCE GEORGIA INDIGENT CARE TRUST FUND FREE AND REDUCED-CHARGE SERVICES PROGRAM AND PATIENT FINANCIAL ASSISTANCE PROGRAM

PATIENT NAME: _____ BIRTHDATE/AGE: _____/_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____-_____ SOCIAL SECURITY #: _____

CIRCLE ONE: EMPLOYED RETIRED DISABLED MINOR UNEMPLOYED MARITAL STATUS M S D W

OCCUPATION: _____ PHONE #: _____

EMPLOYER: _____ HOW LONG?: _____

GUARANTOR'S/SPOUSE'S NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RELATION TO PATIENT: _____ SOCIAL SECURITY #: _____

CIRCLE ONE: EMPLOYED RETIRED DISABLED MINOR UNEMPLOYED MARITAL STATUS M S D W

OCCUPATION: _____ PHONE #: _____

EMPLOYER: _____ HOW LONG?: _____

THE FOLLOWING SECTION MUST BE COMPLETED:

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

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

*If income for 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 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 and is not your legal guardian, that person is not responsible for paying your medical bills, and would not have to be counted or report income.)

As allowed by Georgia State Law, I ask that Memorial Health University Medical Center, Inc. determine my eligibility for help with unpaid hospital bills for services from Memorial Health University Medical Center, Inc. I know that the information I give about my annual income and family size may be checked for accuracy by Memorial Health University Medical Center, Inc. I know that if the information I give is not true, then I will be denied for financial help with my hospital bill and I will have to pay the bill. I also know that I have to inform Memorial Health University Medical Center, Inc. of any changes in my financial status that would allow me to pay my hospital bill, for example, an accident settlement or insurance benefits.

PATIENT/GUARANTOR SIGNATURE: _____ **DATE:** _____/_____/_____

SPOUSE'S SIGNATURE: _____ **DATE:** _____/_____/_____

Memorial HEALTH University Medical Center

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Patient ID Area