Piedmont HEALTHCARE

Financial Assistance Application

APPLICANT INFORMATION **ALL FIELDS MUST BE COMPLETED**

Date of Service (Past or Future):_____ Facility:_____

Patient Full Name:_____ Social Security #:_____

Date of Birth:_____ Physical Address:_____

City:_____ State:_____ Zip:_____

Mailing Address:_____ Medical Record Number:_____

Phone Number: _____ Name of Person Completing Application:_____

Relationship to Patient:_____

Household Members by Legal Name, Including Yourself (Guarantor)

Name (Last, First & MI)	DOB	Age	Relation	Occupation	Security Social #	Annual Income
						$
						$
						$
						$
					TOTAL	$

Sources of Income (if zero then indicate zero in box)

Income	$
Social Security	$
Other Income/Alimony/ Investments/Retirement	$
Total Income	$
401K Balance	$
Mortgage Amount	$
Rent Amount	$
Savings Account Balance	$
Change Healthcare Verification	
If no income how are you supporting yourself?	Describe below:

Other Coverage Questions

Does the patient have health insurance?	❑ Yes ❑ No
Is the patient being treated for injuries covered by third party liability, such as an auto insurance company or Workers Compensation?	❑ Yes ❑ No
Does the patient have Medicaid? – If yes go to page 2	❑ Yes ❑ No
Has the patient applied for Medicaid?	❑ Yes ❑ No
Are you Pregnant?	❑ Yes ❑ No
Are you on Social Security Disability?	❑ Yes ❑ No
Are you over 65?	❑ Yes ❑ No
Are you 19 or younger?	❑ Yes ❑ No
Are you a custodial parent and unemployed?	❑ Yes ❑ No

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Statement: I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and others as required. I authorize my employer to release to Piedmont Healthcare proof of my income. I understand that if any information I have given proves to be untrue, Piedmont Healthcare will re-evaluate my financial status and take whatever action becomes appropriate.

I further agree to make application for any assistance (i.e. Medicare, Medicaid, State Aid (for Cancer), Vocational Rehab, Insurance, etc.) that may be available for payment of my Piedmont Healthcare account charges. I will fully cooperate with Change Healthcare, Piedmont Healthcare's Medicaid Eligibility processor, in taking whatever actions may be deemed necessary to obtain such assistance and will assign or pay Piedmont Healthcare the amount recovered for Piedmont Healthcare charges. Failure to cooperate with Piedmont Healthcare's Medicaid Eligibility Vendor will result in immediate denial of Financial Aid. A complete Financial Assistance Program Application is applicable per guarantor.

Applicant Signature	Applicant Name (**PRINT**)	Date	Time
Witness Signature	Witness Name (**PRINT**)	Date	Time

Documentation to support your application is required in order to process the application. Failure to provide this information could result in your application being denied and you will not be able to appeal the denial decision. You may contact the Financial Aid department if you have questions or need assistance completing the application at:

Documentation Requirements

- Photo ID Acceptable forms (government IDs only):
  - Valid state-issued driver's license (invalid or expired documents are allowed under certain circumstances
  - State ID card
  - Passport
  - Military ID
  - Any consular or school picture ID
  - Visa or Resident Alien card (if applicable)
  - Not Acceptable: Costco card, Selfie or Christmas/holiday picture
- Proof of Residency - Proof of residency documents should not be more than 30 days old, and must be in the patient's name. Acceptable forms:
  - Lease contract- may be used if still valid and all other documents contain the same address
  - Food stamps letter
  - Utilities Bills – with Physical address
  - Other business documents that verify your place of residency, such as credit card statements, IRS, Medicaid letters, student letters from school, bank statements, mortgage statements
    - Note: A P.O. box does not demonstrate residency.
- Proof of Income
  - If Employed: Required documents - Three most recent paycheck stubs (patient and spouse/partner)

    OR
  - If Unemployed: Required documents - Unemployment Claim or Unemployment award letter, and copies of three months' most recent bank statements Checking and Savings – All accounts

    OR
  - If Self-Employed: Required documents - copies of three months' recent bank statements from both personal and business checking/savings accounts (patient and spouse/partner) – All Accounts

    OR
  - If Retired: Required documents – SSN letter (if applicable) and copies of three months' recent bank statements from both personal and business checking/savings accounts (patient and spouse/partner) – All Accounts
    - Medicare SSN Letter - WWW.SSA.gov/myaccount
- AND – The following documents are used to verify information and are NOT a replacement of the above list.
  - Any decision letters indicating that the patient is receiving unemployment compensation, Medicaid, Social Security disability, General Assistance, etc.
  - Food Stamps Letter
  - Verification of homelessness or a letter from a shelter on company letterhead
  - Other business documents showing how the patient is being supported
- Proof of number of dependents
  - Previous years signed income tax return – only needed if claiming dependents
  - Any decision letters indicating that the patient has legal responsibility for the child, such as, court ordered guardianship papers or custody papers