Piedmont HEALTHCARE

# Financial Assistance Application

**APPLICANT INFORMATION**

Date of Service (Past or Future):_____

Patient Full Name:_____ Social Security Number:_____

Date of Birth:_____ Physical Address:_____

City:_____ State:_____ Zip:_____ Employer/Company Name:_____

Mailing Address:_____

Home Phone:_____ Mobile Phone:_____ Medical Record Number:_____

Guarantor Full Name:_____ Social Security Number:_____

Date of Birth:_____ Physical Address:_____

City:_____ State:_____ Zip:_____ Employer/Company Name:_____

Mailing Address:_____

Home Phone:_____ Mobile Phone:_____ Relationship to Patient:_____

**LIST ALL HOUSEHOLD MEMBERS BY LEGAL NAME (Other than Patient/Guarantor listed above)**

| Name (Last, First & Middle Initial) | Date of Birth | Age | Relation to Guarantor | Occupation | Security Social Number | Gross Annual Income |
|---|---|---|---|---|---|---|
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| **MONTHLY LIVING EXPENSES** | **EXPENSES** |
|---|---|
| Medical, including health insurance and monthly medication | |
| Housing and utilities, including rent, cell phone, phone, cable/television, internet, power, gas, water, property tax and/or mortgage | |
| Transportation, including car payments, car insurance and/or monthly transportation | |
| Other living expenses, including day care, child support, tuition and/or alimony | |

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**SOURCE OF HOUSEHOLD INCOME**

| | |
|---|---|
| Employment Income | |
| Social Security | |
| Disability | |
| Unemployment Compensation | |
| Spousal/Child Support | |
| Investment Income | |
| Rental Income | |
| Pension/Retirement Income | |
| Savings or Interest | |
| Other Income or Support | |

| **OTHER COVERAGE QUESTIONS** | **YES/NO** |
|---|---|
| 1. Does the patient have health insurance? | ❑ YES ❑ NO |
| 2. Does the patient have Georgia Medicaid? | ❑ YES ❑ NO |
| 3. Is the patient being treated for injuries covered by worker's compensation? | ❑ YES ❑ NO |
| 4. Is the patient being treated for injuries covered by third party liability such as an auto insurance company? | ❑ YES ❑ NO |

**IF YOU DO NOT HAVE MONTHLY INCOME, PLEASE EXPLAIN HOW YOU TAKE CARE OF YOUR MONTHLY EXPENSES**

**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 appropriate action.

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

**SUPPORTING DOCUMENTATION IS REQUIRED TO PROCESS YOUR APPLICATION. PLEASE REFER TO PAGE 3 OF THIS APPLICATION FOR EXAMPLES OF THE REQUIRED SUPPORTING MATERIALS.**

Piedmont Healthcare, Customer Solutions Center • 2727 Paces Ferry Road, Building 2, Suite 500, Atlanta, GA 30339 •
**Phone**: 1.855.788.1212 • **Fax**: 770.916.7511

- Photo ID – State Issued Driver's License, State ID Card, Passport, or any consular or school picture ID.
- Visa or Residence Alien Card (if applicable)
- Proof of Residency – One to three of the following showing your current street address is required to provide residency:
  - One to three utility bills such as power bill, gas bill, water bill, telephone bill
  - Lease contract
  - Rent receipt showing current address
  - Food stamps letter
  - Voter's Registration Card
  - Other business documents that verify your place of residency, such as: credit card statements, IRS, Medicaid letters, student letters from school, cable bill, cell telephone bills, bank statements, mortgage statements, check stubs showing your address, etc.
  - NOTE: A P.O. Box does not demonstrate residency.
- Proof of Income – one of the following is required:
  - Three current pay check stubs (patient and partner)
  - Unemployment Claim, Department of Labor Wage Inquiry (WG-15)
  - Copies of three months' recent bank statements if living off of savings
  - A letter from employer on company letterhead confirming start date, currently employed, stating the rate of hourly pay, the total amount paid each pay period and how often paid
  - Any decision letters indicating that the patient is receiving unemployment compensation, Medicaid, Social Security disability, General Assistance, etc.
  - Food Stamps Letter and paycheck stubs
  - 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 – one of the following is required:
  - Previous year's signed income tax return (most recent)
  - Any decision letters indicating that the patient has legal responsibility for the child, such as, court ordered guardianship papers or custody papers
  - Birth Certificate for each child age 18 or younger