



## FINANCIAL ASSISTANCE APPLICATION

Patient Name: \_\_\_\_\_

Visit ID: \_\_\_\_\_

You may be eligible for financial assistance under the Federal Poverty Income Guidelines, complete this application and return it with the requested documentation listed below.

**Provide ALL income verification listed below that applies to your Family Unit. (applicant/patient, spouse/significant other, and legal dependents).**

\_\_\_\_\_ **Wages:** Check stubs or statement from your employer indicating the last three (3) checks showing the gross income.

\_\_\_\_\_ **Self-Employed:** If you and/or your spouse are self-employed, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.

\_\_\_\_\_ **Social Security:** 3 of your most recent bank statements. If you do not have a checking account we need 3 verifications of deposits to your bank card issued by social security.

\_\_\_\_\_ **No Income:** If you have no income please provide a statement from the person(s) providing a residence for you.

\_\_\_\_\_ **Tax Returns:** Previous year's income tax return, or \_\_\_\_\_

\_\_\_\_\_ **Other Income:** Proof of any other income source such as child support, alimony, trust funds, or rental property..

\_\_\_\_\_ **Other:** \_\_\_\_\_

**Failure to submit the requested information may result in denial of your application because your financial eligibility could not be determined.** This application is valid for 180 days from your request for Financial Assistance.

Approval under the Financial Assistance Program is effective for charges incurred from Coffee Regional Medical Center only. The program does not cover physician charges such as Pathology, Cardiology, Radiology, private physicians, or prescription medication.

**Return application  
and income proof to:**

**OR**

**Mail the application  
and income proof to:**

**OR**

**Fax to:**

Coffee Regional Medical Center  
Patient Financial Services (PFS)  
196 Westside Drive  
Douglas, GA 31533

Coffee Regional Medical Center  
Patient Financial Services (PFS)  
Attn: Financial Counseling  
P O Box 1227  
Douglas, GA 31534

912-383-6917  
Financial Counseling

**NOTE: Financial assistance will not be considered without income proof and the completed application signed.**



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|                    |                   |
|--------------------|-------------------|
| Applicant/Patient: | Social Security # |
| Mailing Address    | City/State: Zip:  |
| Street Address:    | City/State: Zip:  |
| Home Phone #:      | Cell Phone #      |

**List Members of Family Unit: (defined as applicant, spouse, and all legal dependents as allowed by the Federal Government)**

| Family Member Name | Birth Date | Gender | Relationship to Patient | Social Security # | Employed (yes/no) | Gross Monthly Income |
|--------------------|------------|--------|-------------------------|-------------------|-------------------|----------------------|
|                    |            |        | self                    |                   |                   |                      |
|                    |            |        |                         |                   |                   |                      |
|                    |            |        |                         |                   |                   |                      |
|                    |            |        |                         |                   |                   |                      |
|                    |            |        |                         |                   |                   |                      |

## ASSETS

|                             |    |                                      |    |
|-----------------------------|----|--------------------------------------|----|
| Savings Accounts(s)         | \$ | Checking Accounts(s)                 | \$ |
| Stocks/Bonds (market value) | \$ | Certificate of Deposit(s) Face Value | \$ |
| Recreational Vehicles       | \$ | Savings Accounts(s)                  | \$ |
| Other Assets:               | \$ | Other Assets:                        | \$ |

## DISCLAIMER

By signing below, I agree that I have read and understand the following as it relates to my application for the Financial Assistance Program (FAP) at Coffee Regional Medical Center (CRM).

- \*Incomplete applications and/or documentation of income will result in a denial of my application.
- \*Financial Assistance will only cover bills for CRM charges.
- \*It is my responsibility to immediately notify CRM Financial Counseling or Patient Financial Services of any additional services provided within thirty (30) days from the date of this application.
- \*The billing process will continue on my total balance due until notification of approval.

The information given is true and correct to the best of my knowledge. I understand that any false statements given by me to receive assistance to which I am not entitled may disqualify me from this program and any funds utilized through this program will be voided. Information provided will be used for the purpose of evaluating my financial condition and ability to pay any bills or charges for hospital services that I have received from Coffee Regional Medical Center or any accounts which I have signed as Guarantor. I authorize my employer to release information regarding my income which may be necessary in evaluating my financial needs. I agree to promptly notify Coffee Regional Medical Center of any changes in my financial status affecting my ability to pay. By requesting financial assistance, I agree Coffee Regional Medical Center may inquire into my credit history. Yes\_\_\_\_ No\_\_\_\_.

Signature:\_\_\_\_\_ Date:\_\_\_\_\_