Charity / Indigent Care Checklist & Application

Patient Name:_____ Date:_____

Please read the following information carefully. Note that all requested information must be included with the application prior to processing. An incomplete application may result in denial. Timeliness is extremely important.

Please use the following checklist to make sure you have all the required information before submitting your application.

Proof of income:

☐ Most recent Federal Income Tax forms – required for **every** application.

☐ If anyone in your household (including children under age 18) is employed outside of the home, **one month current** paycheck stubs are required.
**If your child is employed and under age 18, proof of income may be in the form of a pay stub or certified letter.
**If you are not married, but live with someone and have children in common, then his/her income must be included.
**If you are legally separated, you must provide legal documentation of separation or include your spouse's income verification.

☐ Proof of Worker's Compensation; Sick Leave; Disability Compensation; Welfare; Social Security Retirement (SSI); Child Support; or Alimony.

☐ If you are not currently employed and have no income, a statement is required from the person who provides room and board for you and your family.

☐ If you lost your job within the last three months, a separation notice from your previous employer is required. **Additionally,** you will need to provide a letter from the Georgia Department of Labor Career Center specifying whether or not you are receiving unemployment benefits.

Proof of Address:

☐ The following may be used for proof of address (at least 2): 1) Valid Georgia Driver's License, 2) Georgia Identification Card, 3) Current Utility Bill (i.e., Electric, Water, Phone, etc.), 4) Current Lease or rental receipt, which should include the County of residence, 5) County Property Tax Assessment, 6) County Food Stamps letter, or 7) Voter Registration Card.

Proof of Assets:

☐ All Assets shown on the application require supporting documentation. For example, if you have a checking or savings account, then you must provide a current copy of your bank statement.

Miscellaneous:

☐ If you list any children, other than biological or stepchildren, on the application, you must provide legal documentation showing your relationship to the child.

☐ If there is **no** household income listed, you are required to apply for assistance with other entities, such as Medicare, **Medicaid,** or Disability, and provide proof of denial before Charity/Indigent care can be approved.

Applications must be submitted by the 240th day from receipt of the first Appling Healthcare statement for the care provided. This application is not a guarantee that your account will not follow our collection process. Your account **will not** be placed on hold pending consideration of this application, however, Appling Healthcare will not engage in extraordinary collection actions prior to making reasonable efforts to determine your eligibility for financial assistance. You will be contacted to provide information listed above. Failure to complete the application process could result in your account being placed at the collection agency for legal collection purposes and you will not be eligible for the Charity/Indigent Care Program.
You will receive an approval or denial letter upon completion of the application review.

Sincerely,

Malorie Harvill, Financial Counselor
Phone # 912.367.9841 ext. 1278

Charity / Indigent Care Application

Today's Date	Social Security #	Date of Birth	Patient Name	Sex

Account #	Marital Status (check one)	Home Telephone #
	□ Married □ Single □ Divorced □ Widowed	
Address	**City, State, ZIP**	**Cell/Alternate Phone #**

Parent/Guardian Name (if patient is under 21)	Phone #	Address	City, State, ZIP
Parent or Guardian Employer	**Work Phone #**	**Employer Address**	**Type of Work**
Spouse's Employer	**Work Phone #**	**Employer Address**	**Type of Work**

Do you have Insurance coverage?	Medicare	Medicaid	SSI Disability	Are you or your spouse Self Insured?
□ No □ Yes_____	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes

Do your children have Insurance?	Do your children have Medicaid?
□ No □ Yes_____	□ No □ YES Check one: □ Medicaid □ Wellcare □ Amerigroup □ Peach State

List ALL members of your household below (including yourself).

Name	Date of Birth	Social Security #	Relationship
1.			
2.			
3.			
4.			
5.			
6.			

If more than 6 in household, please list the remaining members on a separate sheet of paper.

ASSETS – Please fill in ***each*** line, write N/A if not applicable to you.
You must provide proof of the assets listed below.

Checking Account Balance: $	
Savings Account Balance: $	
Other: (CD's, Mutual Funds, 401K) $	

INCOME INFORMATION – Please provide last 4 paycheck stubs of ***all employed*** (including children) members of household. A copy of the most recent federal income tax return filed. **Proof** of workers compensation, sick leave, disability compensation, child support, alimony, welfare, or social security retirement (SSI), if applicable.

Name	Source of Income	Amount	Pay Frequency
Patient:			□ Monthly □ Weekly □ Bi-weekly
Spouse:			□ Monthly □ Weekly □ Bi-weekly
Child:			□ Monthly □ Weekly □ Bi-weekly
Child:			□ Monthly □ Weekly □ Bi-weekly
Child:			□ Monthly □ Weekly □ Bi-weekly
Other (please specify):			

Charity / Indigent Care Application

Consent, Authorization, and Attestation:

Please read and initial each line item below:

____ I certify that this form has been examined by me and that the information is true and correct to the best of my knowledge.

____ I, and my Spouse if applicable, agree to provide Appling Healthcare System with any written documentation needed to verify the information provided on the application and hereby grant permission for Appling Hospital System personnel to obtain such information on my/our behalf.

____ I understand that additional information may be requested in order to process this application.

____ I understand that I must apply for any other benefits, which might pay for the services received at Appling Healthcare System before Charity Care can be approved (i.e., Medicare, Medicaid, Disability, etc.).

____ I understand that any assistance provided is for my benefit only and will be based solely on the information disclosed. No release or write-off is granted in connection with any third party liability, whether the liability arises by contact or negligence. A hospital lien may have been filed, naming me as the injured party. Any money recovered as a result of a hospital lien will result in a reversal of the charity discount, up to the amount of the recovery.

____ I understand that if I provide false information, any assistance previously granted will be reversed and LEGAL ACTION may be pursued.

____ I understand that my application will be denied if it is incomplete or if I fail to provide the required documentation.

Signature of Patient or Guardian:_____ Date:_____

Relationship to Patient:_____

Signature of Spouse (if applicable):_____ Date:_____

Please do not write below this line – for office use only.

Date Application Received:_____ Received by (Employee Initials):_____

Date of Service:_____ Account #:_____ Amount:_____
Date of Service:_____ Account #:_____ Amount:_____
Date of Service:_____ Account #:_____ Amount:_____
Date of Service:_____ Account #:_____ Amount:_____
Date of Service:_____ Account #:_____ Amount:_____

Income/Assets/Liabilities Verified: ☐ Yes ☐ No Total Amount of Charges:_____

Total Household size:_____ Total Household Income:_____ ☐ Monthly ☐ Yearly

Application Approved: ☐ _____% Eligible Discount Patient Class: ☐ Self-Pay ☐ Insurance ☐ Medicare

Application Denied: ☐ Household income over limits ☐ Incomplete Application ☐ Other:_____

Notification Letter Mailed:_____ Employee Signature:_____

Reconsideration Result:_____ Notification mailed:_____