Union County General Hospital

CLAYTON HEALTH SYSTEMS, INC

Financial Assistance Application

_____ _____
Print Patient Name Account No. or Social Security No.

_____ _____
Print Guarantor/Parent Name (if different from above) Social Security No.

Instructions: All questions must be answered. If a question does not pertain, write N/A on the line. Attach a photocopy of **one of the following** proofs of **income** to the completed form:
1. Letter of support from friend/family. Written Attestation signed.
2. Last year's tax return statement
3. Social Security check or award letter
4. Last 2 paycheck stubs
5. Unemployment or Food Stamp award letter
6. Letter from employer- (to include employee name, hourly wage, number of hours worked.)
7. Physician Disability Statement
8. Bank Statement/Records

Citizenship (check one): _____US Citizen _____Non-US Citizen

Marital Status (check one): ____Married ____Single ___Divorced ___Separated ____Widowed

Name of Dependents **(legal deductions on your tax return)** Number in the Household_____

Name: _____Relationship: _____ Date of Birth_____
Name: _____Relationship: _____ Date of Birth_____
Name: _____Relationship: _____ Date of Birth_____
Name: _____Relationship: _____ Date of Birth_____
Name: _____Relationship: _____ Date of Birth_____

Housing (check one): ____Own _____Rent ____Paid House/Rent Payment $_____/month

Utilities: Electricity $_____/month Gas $_____ /month Water $_____/month

Automobiles: Own (How many?) _____ Lease (How many?) _____ Car Payment (s): $_____/month

Bank Accounts/Other Assets: **(must answer all three questions)** Attach a photocopy of bank statement.

PLEASE INCLUDE A COPY OF YOUR RECENT BANK STATEMENT FOR ANY BANK ACCOUNTS YOU MAY HAVE

Checking Account? (Circle One) Yes or No $_____
Savings Account? (Circle One) Yes or No $_____
Additional Assets? (Circle One) Yes or No
Describe: _____
(Include vehicles year/make/model)

Employment-PATIENT/GUARANTOR Name of Employer:

_____

Employment-SPOUSE Name of Employer:

_____

Patient/Guarantor	Spouse
_____ Employed Full Time	_____ Employed Full Time
_____ Employed Part Time	_____ Employed Part Time
_____ Not Employed	_____ Not Employed

Other Support:

Social Security $_____/month
Child Support $_____/month
Trust Fund $_____/month
Survivors Benefit $_____/month
Unemployment $_____/month
Workman's Comp $_____/month

Total Family Income $_____ per month (Award requires proof of income with application)

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patient's family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. I understand this determination is conditional and does not apply to third party claims such as lawsuits, settlements, hospital liens, or any other third-party payment or liability. Clayton Health Systems, Inc retains its rights to recover the full balance of my bill from any third-party resource to the fullest extent allowed by law. If my (our) case is selected for Indigent Care classification, I (we) give my (our) consent to the Clayton Health Systems, Inc to obtain information from any source to verify the statements I (we) have made.

_____ _____

Parent/Guarantor Signature Date

Union County General Hospital

FINANCIAL ASSISTANCE APPROVAL WORKSHEET

Office use only

Name: _____ Patient Account Number(s)_____

Based off of Information from Application:

Circle appropriate answer in response to the following questions:

1. Is Total Gross Annual Income equal to or less than 200% of the Federal Poverty Guidelines?

(See Hospital Financial Assistance Eligibility Guidelines — Schedule A – Part 1 – Financially Indigent)

YES Approved for 100% financial assistance as Financially Indigent

NO Does not qualify for assistance as Financially Indigent. Continue to Step 2.

2. Is balance due after payment by all third-party payors equal to or greater than 10% of Total Yearly Income?

YES Continue to Step 3.

NO Patient does not qualify for Financial Assistance.

3. Is Total Gross Annual Household Income equal to or less than 400% of the Federal Poverty Guidelines?

YES Total Yearly Income is less than _____% of the Federal Poverty Guidelines. Approved for ____ % discount as Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule A – Part 2

NO Continue to Step 4.

4. Is balance due after payment by all third-party payors equal to or greater than 50% of Total Yearly Income?

YES Balance due is _____ % of the total yearly income. Eligible for _____% discount as Catastrophically Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule A – Part 3.

NO Patient does not qualify for Financial Assistance.

I. ($ _____) X (_____ %) = $ _____ 2. ($_____) - ($ _____) = $ _____

*Balance Due*_____*% Discount*____*Discount Amount* _____ *Balance Due*_____ *Discount Amt. Remaining Bal. Due*

_____

Employee Signature Date

If Discount = $1 - $5,000 Approved by CFO ----------

If Discount = Above $5,000: Approved by CEO ----------