Southern Surgery Center, LLC

FINANCIAL ASSISTANCE APPLICATION FORM

Patient Name: _____

Social Security Number: _____ DOB: _____

Marital status: Single/ Married/ Separated/ Divorced/ Widowed

Address:_____

City:_____ State & County:_____ Zip:_____

Primary Number: _____ Secondary Number: _____

Employer: _____

Address:_____

City:_____ State & County:_____ Zip:_____

Work Number: _____ Ext: _____

Work Status: Full Time / Part Time / Un-Employed / Self-Employed / Retired / Student

FAMILY MEMBERS IN HOUSEHOLD

Name	Birth Date	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

THIRD PARTY INFORMATION

Are you covered by Medicaid? Yes _____ No _____

If yes, Medicaid Number _____

Coverage Dates: From _____ To _____

Are you covered by Medicare?Yes _____ No _____

If yes, Medicare Number _____

Other Health Insurance? Yes _____ No _____

Company _____

Policy # _____

Is admission due to an accident? Yes _____ No _____

If yes, date of accident _____

Is Claim Pending? Yes _____ No _____

Was accident work related? Yes _____ No _____

If accident work related, name of employer and address:

_____

_____

_____

GROSS MONTHLY INCOME FOR PATIENT AND LEGALLY RESPONSIBLE RELATIVES

$_____ Wages $_____ Spouse/Partner Wages
$_____ Social Security $_____ Pension Retirement
$_____ Unemployment $_____ Workers Compensation
$_____ Child Support $_____ Annuity/Dividends/ Awards / Settlements

$_____ Other – please describe

_____

_____

_____

_____

$_____ Total Monthly Income $_____ Total Annual Income

You must return copies of the following documents with this application. Any application without signature and the necessary documentation will be denied.

DOCUMENTATION CHECK OFF LIST – Only documents that are applicable to your employment status

☐ Proof of income: 2 most recent pay stubs or verification from employers/ previous year tax return.

☐ Social Security Award Letter for current year

☐ Unemployment Compensation Benefit Letter

☐ Statement from Attorney regarding case details (Auto or Workers Comp)

The following documentation must be provided in order to process your Charity/Indigent Care application: Proof of household income via two most recent pay stub/previous year tax return. If self-employed, provide a copy of most recent federal income tax filed. Proof of workers compensation, sick leave, disability compensation, welfare, or social security retirement if applicable.

If you are not married but there are children in common, you must provide entire household income. Any child support or alimony received must also be included.

If you are still legally married but separated, you must provide legal documentation of separation or spouse's income.

If you lost your job within the last three months, you are required to provide a separation letter from your past employer. Additionally, you must provide a letter from your local Georgia Department of Labor Career Center specifying whether or not you are receiving unemployment benefits. If you have no income at this time, provide a signed and notarized letter from the person who provides room and board for you and your family, if applicable.

Proof of home address: valid Georgia driver's license, Georgia identification card, current utility bill, lease or rent receipts showing evidence of county of residence, county property tax assessment, county food stamp letter, voter registration card.

You are required to return all information within the next 15 days. This application is not a guarantee that your account will not follow our collection process. Your accounts will not be placed on hold pending charity consideration.
You will receive an approval or denial letter upon completion of application review.

ADDITIONAL NOTES OR COMMENTS:

Please feel free to describe any special circumstances or any other information that you feel would be important concerning your application for financial assistance.

_____

_____

_____

Please submit the completed forms and all requested documentation to:

Ashlee Daniel, RN
Southern Surgery Center, LLC
605 North Westover Blvd.
Albany, GA 31707

Please contact the Financial Specialist at (229)434-4211 if you have questions or require any assistance.

AUTHORIZATION AND AGREEMENT

I understand that the information that I submit is subject to verification by Southern Surgery Center, LLC. I certify that the above information and all documentation provided are true, correct, and complete. I understand that if I have deliberately given any false information or withheld any information I am liable for prosecution for fraud. Also, any discount awarded will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances. I understand that I may be required to provide additional documentation in order to process my application. I understand that I must apply for any other benefits which might pay these accounts before charity can be approved (e.g., Medicaid, Medicare, County Hospitalization, Disability, etc.). I understand that the above write-off is for my benefit only and based solely on the disclosure in my application. I understand that my application will be denied if it is incomplete or I fail to provide required documentation.

Signature _____ Date _____

FOR INTERNAL USE ONLY

Acct #: _____

Discount Determination:

Whole Claim:_____ Partial Claim: _____

Indigent Care:_____ Charity Care: _____

	DATE	INITIAL
Date Application Received		
Income / Assets Verified		
Discount Percentage		
Discount Amount		
Patient Notified		

Billing Mng Signature: _____

Date: _____

Approval Physcian Signature : _____

Date: _____