Helping Hands Financial Assistance Program Application

It is our pleasure to extend financial assistance for those unable to pay for emergent or non-emergent hospital services, provided those services are deemed medically necessary.

This application may be completed for consideration within 240 days of the first post-discharge statement. Proof of income must accompany the application, and a valid mailing address for correspondence must be provided.

Documentation accepted for proof of income purposes includes, but is not limited to, most recent tax return, social security award letter, unemployment pay stubs, bank statements showing payroll direct deposits, food stamp assistance letter, or last two months payroll check stubs. Please send copies only, as original documentation may not be returned.

Applications should be completed and returned to EHS with proof of income documentation. Unanswered items or missing documentation will delay processing, and the file may be closed if the items aren't submitted within ten days of notice of an incomplete application packet. It is the patient or guarantor's responsibility to provide us with a valid mailing address for all correspondence, and notices of approval, denial or outstanding information will be mailed to the address on file.

Assistance with the application is available at the facility, or you may call **754-0496** with any questions. Our mailing address is **EHS P.O. Box 386 Springfield, Georgia 31329**. PLEASE BE ADVISED THAT THIS APPLICATION COVERS HOSPITAL BALANCES ONLY. NO ASSISTANCE IS AVAILABLE FOR PHYSICIAN CHARGES.

Our Helping Hands Financial Assistance policy is available for review on the EHS website: www.effinghamhealth.org. Applications, as well as a Plain Language Summary of the assistance program are also available online.

Questions: EFFINGHAM HEALTH SYSTEM BUSINESS OFFICE: 754-0496

Name of Patient: _____ Account # _____

Name of Guarantor if different from Patient: _____

SS # of person applying for assistance: _____

Physical Address of applicant:

Complete Mailing Address: (if different than physical address, be sure to include any apartment # or lot # needed for delivery)

Telephone # if we have questions: _____

Name of anyone who may assist with your bills: _____

_____

Do you have Medicare or Medicaid? ___ yes ___ no

ID# _____ (you may also attach a copy of the identification card)

Have you ever applied for either Medicaid / Medicare? ___ yes ___ no

Date applied & results? _____

Do you have other medical insurance that was active on the date of service?

___ yes ___ no (if yes, please attach a copy of the ID card to this application)

How many adults in household? _____ How many minor children? _____

List of household members, including date of birth, relationship and income: (please list names and information for each household member below, and indicate if income is weekly, bi-weekly or monthly)

Name	DOB	Relationship	Income

Total # in household: ____ Total monthly household income: _____

***Note to applicant: You do not need to report income for a household member who is not legally responsible for the patient's medical bills. For example, if a parent or sibling is currently living with you, but is not responsible for the patient's medical bills, they do not have to be counted as part of the household*.**

Please check any income sources that apply and provide monthly $ amount:

Wages received from employer	**_____**	**$_____**
Self employed wages	**_____**	**$_____**
Public assistance		
Food Stamps	**_____**	**$_____**
AFDC	**_____**	**$_____**
Social Security	**_____**	**$_____**
Unemployment Benefits	**_____**	**$_____**
Strike Benefits	**_____**	**$_____**
Alimony	**_____**	**$_____**
Child Support	**_____**	**$_____**
Military Family Allotment	**_____**	**$_____**
Pension	**_____**	**$_____**
Interest / Dividends	**_____**	**$_____**
Other Income	**_____**	**$_____**

Total Income **$_____**

I affirm that the above information is true and correct to the best of my knowledge. I understand that I will be guilty of deceit and / or fraud if I have knowingly answered these questions untruthfully. Effingham Health System has my permission to verify the information provided with agencies, companies or employers listed in this application. I further understand this application does not guarantee or constitute assistance, nor is this a contract which is binding for Effingham Health System.

Signature: _____ Date: _____