Hampton Regional
MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

Patient Name _____Date of Birth _____Marital Status_____

County of Residence_____ Social Security # _____

Guarantor Name _____Social Security # _____
Person responsible for Patient's Balance

Mailing Address _____City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Guarantor's Employer_____
Employer Name/Address/PhoneNumber/Date of Hire

Guarantor, if not working, when was your last date of employment? _____

Spouse's Employer_____
Employer Name/Address/Phone Number/Date of Hire

Spouse, if not working, when was your last date of employment? _____

Are you a South Carolina Resident? Yes or No Are you a U.S. Citizen? Yes or No

You must provide a legible copy of a valid S.C. Driver's License or a valid S.C. picture ID. If you are not a U.S. citizen, you must also provide a legible copy of a valid green card.

INSURANCE ELIGIBILITY

Do you or your spouse have Insurance? Name of Insurance _____Insurance ID_____

Do you qualify for Medicaid:

Are you disabled? _____ Are you pregnant? _____ Are you blind? _____ Are you a caretaker relative living with a child under age 18? _____ Are you 65? _____ Are you under age 19? _____

If you answered Yes to any of the above, have you applied for Medicaid?_____

Do you qualify for Family Planning? Yes or No Food Stamps? Yes or No

INCOME

List all household members/dependents as claimed on your Federal Income Taxes. If a person listed below is not claimed on your taxes, you must provide at least one of the following documents for each person: Birth Certificate, Immunization Record, Social Security Card, Current Medicaid Eligibility Letter, Custody Records or Legal Guardianship Document, School Records OR any reasonable document which shows the parent/guardian-child relationship. Income Source includes the gross income from the following sources: Wages, SSI, SSA, Disability Income, Worker's Comp, VA benefits, Retirement/Pension, Child Support, Alimony, Unemployment, Dividends, Annuity Payments, (Gross: Self-Employment Income, Rental Income, Partnership Income), Interest, Sale of Stocks, Foster Care or Adoption Income.

Name	SSN	Relationship to Applicant	Date of Birth	Income Source	Gross Income (Monthly)
Guarantor					$
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					
Total Income					$
Total Expenses					$

RESOURCES

List all assets you or your family member may own. Assets include real property(home, land, buildings, life states, mobile homes.etc.), taxable personal property(cars, trucks, boats, motorcycles, or any other kind of vehicle), liquid assets(cash on had, checking accounts, savings accounts, U.S. Savings bonds, Stocks, trust funds, CD's, life insurance, individual retirement acconts, etc.).

Asset	Value

CERTIFICATION

I certify that I have read or had read to me all the statements on this application and that the information given is true and accurate to the best of my knowledge. I understand that all the above information is subject to review by HRMC and the State and Federal agencies as required certifying the above information is true and correct.

I further authorize the release of any information, including financial information, needed to determine my eligibility for the Financial Assistance Program. I understand and hereby authorize Hampton Regional Medical Center and its affiliates , their collection agencies or attorneys to verify the information contained in this application, including obtaining and reviewing my credit reports or that of the patient, guarantor and/or responsible party. I understand that I may be asked to provide additional supporting documents to verify my South Carolina residency, the number of dependents I am claiming and proof of income to aid in the determination of my financial status.

If supporting documentation is not provided with the application, Financial Assistance will be denied. If partial assistance is approved, the guarantor will be required to pay the remaining balance. Failure to make the payments according to the arrangements may result in cancellation of the Financial Assistance and the full amount may be due.

Signature_____ Date_____

Please sign and date this application.

Mail this completed form with the required documentation (see list below) to: HRMC, Patient Financial Services, PO Box 338, Varnville, SC 29944

OFFICE USE ONLY

Patient Account #_____

Approved by _____ Date_____

Percentage (%) Approved _____ Effective Dates: _____to _____

Denied by_____ Date _____

Reason for Denial

_____

_____

COMMENTS

_____

_____

_____

Approved Document List for the Financial Assistance Program

I. IDENTITY :(PROVIDE ONE OR MORE) - must have applicants picture

- South Carolina driver's license
- State I.D. card (from any state)
- Employee Badge
- Alien registration card or resident visa, green card
- Passport
- Student I.D. card or Military I.D. card

II. RESIDENCY: (PROVIDE ONE OR MORE) - must have current address

- Current South Carolina driver's license
- Current utility bill or utility receipt(no more than 30 days old) – gas, water, electric, cable or land line/cell telephone bill
- Social Security award letter or current check stub
- Current Medicaid eligibility letter
- Current complete bank statement, current complete savings statement
- Current billing statement or business mail from county or city tax notices
- Current rent receipt or lease agreement which indicates address
- Vehicle registration
- Mortgage documents or Loan documents
- If you are living with a relative or friend, you must have a letter of support attached, along with proof of residence listed above

III. DEPENDENTS: (INCLUDING SPOUSE AS A DEPENDENT) – if not shown on tax return, provide one of the following

- Current Medicaid eligibility letter
- Social Security card(s)
- Birth Certificate(s)
- Custody records or legal guardianship document
- School records
- Any reasonable document which shows the parent (guardian) –child relationship

IV. INCOME: (PROVIDE ALL THAT APPLY)

- One month of pay stubs(if paid weekly provide the four (4) most recent paycheck stubs; two (2) stubs if paid biweekly: one(1) stub if paid monthly OR current letter from employer on company letterhead
- Most recent three (3) consecutive months of bank statements (current checking, savings, interest income, trusts or dividends)
- Current retirement income check stub(s), pension or annuity income
- Current Social Security award letter OR Disability Benefit Award Letter for both spouses and any children
- Current Veterans Administration award letter
- Current child support statement (stub(s) of divorce decree)
- Current documentation from the South Carolina Employment Commission showing weekly benefits or denial of benefits
- Current previous year 1040 Federal income tax form with ALL schedules and attachments
- Most recent W-2 or Form 1099
- Current proof you are receiving Subsidized Section 8 housing, current food stamps award letter