Phoebe

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Financial Assistance Application

○ **Phoebe Putney Memorial Hospital**
○ **Phoebe Sumter Medical Center**
○ **Phoebe Worth Medical Center**

PATIENT INFORMATION U.S. Resident ○ Yes ○ No

Name: _____ SS# _____ Birthdate: ___/___/___

GUARANTOR and SPOUSE INFORMATION Single ○ Married ○ Divorced ○ Separated ○ Widowed ○

Name: _____ SS# _____ Relationship to Patient: _____

Birthdate: ___/___/___ Home Address: _____

Phone # (___) _____ Other Phone #: (___) _____

Employer: _____ Address: _____

Work #: (___) _____ Position: _____ Annual or Hourly Pay: $ _____ Working Full or Part-time (circle one)

Spouse/ Household Name _____ SS# _____ Birthdate: ___/___/___

Employer: _____ Address: _____

Work #: (___) _____ Position: _____ Annual or Hourly Pay: $ _____ Working Full or Part-time (circle one)

Legal Dependents **(List only those dependents that can be claim on your federal tax form.)**

Name (First, Middle, Last)	**Birthdate (mm/dd/yyyy)**	**Relationship**
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

Have you applied for Medicaid?
Yes ○ No ○

Do you qualify for COBRA?
Yes ○ No ○

Do you qualify for coverage through the Health Insurance Exchange?
Yes ○ No ○

Assets and Other Income Sources

Checking Balance $ _____ Name of Bank _____ Savings Balance $ _____ Name of Bank _____

Monthly Pension $ _____ Social Security $ _____ IRA $ _____ CDs $ _____ Food Stamps $ _____

401K $ _____ Home/Land Owner: (circle one) Yes or No If yes, how many acres? _____ Value $ _____

Do you own rental property? Yes or No (circle one) If yes, what is the monthly income? $ _____ What is the property value? $ _____

Have you filed for bankruptcy in the past 3 years? Yes or No (circle one) If yes, provide the date? ___/___/___

Do you own stocks or bonds? Yes or No (circle one) If yes, what is the value? $ _____

Do you have life insurance? Yes or No (circle one) If yes, what is the value? $ _____

Do you own any recreational vehicles? Yes or No (circle one) If yes, what type and what is the value? $ _____

Comments:

I certify that the information contained on this application and with the accompanying documents and schedules is true and accurate to the best of my knowledge. I understand that Phoebe may verify any information given in this application and that any inaccurate or incomplete information may disqualify me and my family from eligibility and benefits under the Financial Assistance Program. I agree to apply for assistance from Medicare, Medicaid and/or other insurances if perceived to be available to me or the patient for whom I am responsible prior to submitting this application for assistance from the Financial Assistance Program. I will take any action reasonably necessary to obtain such assistance and will assign or pay to Phoebe any amounts received under these assistance programs. If eligible for benefits under the Financial Assistance Program, I agree to abide by the Program's guidelines and accept responsibility for payment of amounts not covered by the Program. My signature certifies: The information I have provided is true and accurate to the best of my knowledge. Phoebe and its affiliates, has permission to audit and verify the information I have provided, including verifying my employment, assets and credit history. I agree to report all changes to income, insurance, assets and family circumstances to the Financial Assistance Program. Failure to comply may result in termination from the program. I understand fully and accept responsibility for meeting these requirements.

Guarantor Signature _____ **Date** _____

Co-Guarantor Signature _____ **Date** _____

Last Updated 7/31/2016