FINANCIAL ASSISTANCE
SCREENING APPLICATION

Patient Name: _____ Account #: _____

Current Address: _____ Phone Number: _____

You have informed us that you are unable to pay for the healthcare services that you have received. Therefore, you may be eligible for financial assistance. However, in order to be considered for this you will need to answer the following questions:

		Yes	No
1.	Are you employed at this time?	☐	☐
2.	Do you have any self-employment income?	☐	☐
3.	Do you have retirement, social security, or disability income?	☐	☐
4.	Are you married?	☐	☐
	If yes, is your spouse covered under Medical Insurance that will pay for your hospital bills?	☐	☐
5.	Do you have any credit cards (Visa, MasterCard, Discover) that you could use to pay your physician bill?	☐	☐
6.	Do you have a savings or checking account?	☐	☐
7.	Is someone providing room and board for you?	☐	☐

If yes, what is their name and relationship to you?
Name: _____ Relationship: _____

8. Will this person confirm in writing the level of support they give to you? If so, please provide a name, address and phone number.

_____

_____

If you have no support, how do you pay for your living expenses? _____

9. What is your estimated annual income from all sources?
Source _____ Dollar Amount _____
Source _____ Dollar Amount _____

10. If appropriate, please fill out the attached list of medical expenses that you have not been able to pay or that have outstanding balances.

I attest that the above information and all documentation provided are complete and accurate as shown. I realize that at any time, should any of this information prove to be false, I will accept responsibility for full payment of the balance. I understand that a credit inquiry may be conducted in order to evaluate my eligibility.

Requested By: _____ Date: _____
(Print Patient Name)

Patient Signature:
(or Guardian if minor) _____ Date: _____

Witness: _____ Date: _____
Print Name Signature

GOLF SURGICAL CENTER
Charity Care Program Application
Patient Responsibility Statement and Communication

It is the responsibility of the patient or their representative(s) to provide all information requested to determine eligibility in a timely and forthright manner. Failure to do so may adversely affect consideration of the patient's application for charity care consideration.

1. Family income is defined as gross earning reportable to the federal government. Income documentation is defined as one or more of the following, and must be provided prior to the adjudication of the application:

a. Prior year's income tax return
b. Most recent W-2 form
c. Paycheck stubs or employer statement documenting wages for three (3) or more months prior to the application for assistance.
d. If no documentation is available, a signed statement which testifies to the patient's financial status may be provided by the person(s) providing financial support to the patient.
e. Applicants whose current financial position is not adequately reflected by the above income reports may submit, or be required to submit, additional statements and/or documentation which more completely describes any extenuating circumstances affecting their financial position (i.e., an individual who is temporarily disables may submit a physician's report documenting his/her inability to work for a given period of time.)
f. Current IDPA spend down form.
g. IDPA eligibility documentation, but reimbursement not available (due to out-of-state program or discontinued program.

2. The amount of financial assistance approved will be determined using guidelines which include, but are not limited to, income, assets and medical expenses. Annual family income is evaluated using the charity care eligibility guidelines. Consideration will be given to extenuating factors such as recent changes in family income, medical expenses and other extraordinary expense items. Consideration of assets and other factors will also be incorporated into the final determination of charity care eligibility if these assets and other factors are material to determining ability to pay.

3. Completed applications are logged on the "Application for Financial Assistance Log" by the Business Office Supervisor who then forwards the package with support information to the manager for further review.

4. The Financial Directors evaluates the request and makes a recommendation based on the patient's circumstances and the current charity care eligibility and discount criteria. After approval, a copy of the notification will be placed in a patient financial file and sent to the patient.

5. Decisions are documented and reported promptly to the applicant utilizing the applicable letter. A copy of the notification will also be sent to the patient's attending physician as appropriate and consistent with Golf Surgical Center's patient confidentiality policies.

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SCREENING APPLICATION

Medical Expenses and Outstanding Balances

Patient Name: _____ Account #: _____

Current Address: _____ Phone Number: _____

Name of Medical Facility, Physician, Physician Group	Month/Year Billed	Dollar Amount