P.O. Box 40010, Mobile, AL 36640 • 251-434-3505

Financial Assistance Application

Patient Information

Patient Name: _____ (Last / First / M.I.)

Account Number: _____

Address: _____ (Street address / Apt/Unit #)

Facility Name: _____

_____ (City / State / Zip Code)

Phone: ( )

Date of Birth: _____

SSN _____

Marital Status: _____

Guarantor Information (If different from patient)

Guarantor Name: _____ (Last / First / M.I.)

SSN: _____

Address: _____ (Street address / Apt/Unit #)

Date of Birth: _____

_____ (City / State / Zip Code)

Phone: ( )

Marital Status: _____

Relationship to Patient: _____

Patient/Guarantor Spouse Information (If applicable)

Spouse Name: _____ (Last / First / M.I.)

SSN: _____

Address: _____ (Street address / Apt/Unit #)

Date of Birth: _____

_____ (City / State / Zip Code)

Phone: ( )

Household Information

Name and Ages of Persons Living in Household:

Name	Age	Relationship	Do you claim this person for tax purposes?

Employment Income

Must provide 3 most recent pay stubs, letter from employer on company letterhead, signed and dated or most recently filed income tax return.

Patient/Guarantor

Employer 1:		Job Title:	
Address:		Phone:	
Gross Income:	Monthly	Net Income:	
Employer 2:		Job Title:	
Address:		Phone:	
Gross Income:	Monthly	Net Income:	

Patient/Guarantor Spouse

Employer 1:		Job Title:	
Address		Phone:	
Gross Income:	Monthly	Net Income:	
Employer 2:		Job Title:	
Address:		Phone:	
Gross Income:	Monthly	Net Income:	

Other Income

Total Gross Monthly Income for the last 30 days. If you do not have an income to report for a specific field, please enter 0. Statements that support the income reported are required. Three (3) banks statements required.

	Patient/Guarantor Amount Per Month	Spouse Amount Per Month	Required Documents
Social Security Payment			Copy of award letter/certificate, correspondence from the U.S. Social Security Administration, or copy of bank account statement (if Social Security is directly deposited).
Unemployment Compensation			Copy of award letter/certificate, monthly benefit statement from Department of Labor or copy of bank account statement showing direct deposit (if compensation is directly deposited).
Disability Payment			Copy of award letter/certificate, correspondence from Social Security Administration, or copy of annual benefit letter.
Workers Compensation			Copy of award letter, check Stub or copy of bank account statement showing direct deposit (if compensation is directly deposited).
Alimony / Child Support			Copy of divorce decree showing alimony amount awarded, copy of check received or copy of bank account statement (if support is directly deposited).
Pension			Copy of check received, award letter (if available) or copy of bank account statement (if payment is directly deposited).
VA Benefits			Copy of check received, award letter from Veteran's Administration (if available), or copy of bank account statement (if benefit is directly deposited).
Public Assistance			Copy of acceptance letter from Department of Social Services indicating the monthly amount received.
Additional Employment Wages			Copy of check received or copy of bank account statement showing income received (if directly deposited).
Other Income			Letter stating the amount of non-wage earnings or copy of check received (if any).

Financial Assets

Balance of current asset accounts for both Patient/Guarantor and Patient/Guarantors Spouse.
Bank Statements that support the asset information reported are required for each account.

	Patient/Guarantor Balance	Spouse Balance	Total Balance
Cash			
Checking Account (Include Joint Accounts)			
Savings Account (Include Joint Accounts)			
Investment Accounts			
Stocks/Bonds			
Trust Funds			
Money Market			
Mutual Funds			
Other			

Disclaimer and signature

I certify that the above information is true and accurate to the best of my knowledge. Furthermore, I will make applications for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available to pay for my hospital charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can judge my eligibility for financial assistance. USA Health reserves the right to verify all given information with credit bureaus and any other persons or creditors they see fit. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature _____ Date: _____

Eligibility Determination • FOR OFFICE USE ONLY

Patient Qualifies Yes ☐ No ☐

The applicant's request for Financial Assistance has been denied for the following reasons:

_____

_____

_____

_____

Date of Determination: _____ Date Applicant Notified: _____

Hospital Representative Signature: _____ Date: _____