Hospital Financial Assistance Program Application

P.O. Box 670747, Marietta, GA 30066
Phone: 470-245-9998

PATIENT INFORMATION U.S. Resident: ◯ Yes ◯ No

Account Number: _____ Facility Name: _____

Patient Name: _____ SS#: _____ Birthdate: _____

GUARANTOR and SPOUSE INFORMATION Married ◯ Divorced ◯ Separated ◯ Widow ◯ Single ◯

Guarantor Name: _____ SS#:_____ Relationship to Patient: _____

Birthdate:_____/_____/_____ Home Address: _____

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

Employer 1: _____ Address:_____ _____

Work #:_____ Position: _____ Annual or Hourly Pay: _____ Working Full time, Part time, or Unemployed (circle one)

Employer 2: _____ Address:_____ _____

Work #:_____ Position: _____ Annual or Hourly Pay: _____ Working Full time, Part time, or Unemployed (circle one)

Spouse's Name: _____ SS#: _____ Birthdate:_____/_____/_____

Employer 1: _____ Address:_____ _____

Work #:_____ Position: _____ Annual or Hourly Pay: _____ Working Full time, Part time, or Unemployed (circle one)

Employer 2: _____ Address:_____ _____

Work #:_____ Position: _____ Annual or Hourly Pay: _____ Working Full time, Part time, or Unemployed (circle one)

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

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

Have you applied for Medicaid? Yes _____ No_____

Do you qualify for Cobra? Yes _____ No_____

Assets and Other Income Sources

Checking Balance: $_____ Bank Name: _____ Savings Balance: $ _____ Bank Name: _____

Money Market Balance: $_____ Bank Name: _____ Social Security: $_____ Monthly Pension:$_____

Alimony: $_____ Child Support: $_____ CDs: _____

Any other assets, i.e. stocks, bonds, etc.: Type: _____ Value ($):_____

Do you receive Student Loan Refunds? Yes or No (Circle One) Student Refunds Amount: $ _____

Have you filed for bankruptcy in the past 3 years? Yes or No (Circle One) If yes, provide the date: _____/_____/_____

Do you own any rental property? Yes or No (Circle One) If yes, what is the monthly income? $_____ Property's Value: $_____

WellStar Health System is committed to providing financial assistance to patients who have sought medically necessary care at WellStar Hospitals but have limited or no means to pay for that care. WellStar will provide emergency medical care to all individuals, regardless of their ability to pay or eligibility under its Financial Assistance Program.

In order to qualify for financial assistance for WellStar hospital, cooperation with WellStar is necessary in identifying and determining alternative sources of payment or coverage from public and private payment programs. In order to qualify for financial assistance, the following is necessary:

Application information:
Submit a true, accurate, signed and completed application for financial assistance; and

All applicants for Financial Assistance must provide proof of Household Income and Household Assets by providing the following that are applicable:

Provide the following documents based on CURRENT financial situation:

☐ Provide three (3) months of the most recent paycheck stubs or a statement from employer verifying gross wages AND the most recent two (2) months of bank statements for each checking, savings, money market or other bank or investment account for the household

☐ Most recent IRS Form 1040 AND IRS W-2/1099 (if applicable) issued during the past year to match IRS Form 1040

Additional Documentation (if applicable):

☐ Written statements for the most recent two (2) months for all other income (e.g., unemployment compensation, disability, retirement, student loans, award letter from Social Security Office, current Profit and Loss report for all self-employed applicants, court ordered alimony documentation, court ordered child support documentation, or Benefit Card Activity Statement (TANF), etc. for the household)

☐ If Unemployed less than 3 months--Separation Notification from Previous Employer

☐ If Unemployed more than 3 months--Wage Inquiry (Department of Labor)

☐ Unemployment compensation denial letter

☐ Documentation of asset values, including, without limitation, property tax statements, Certificates of Deposit, and other investment statements

☐ Contribution statements from individuals who contribute income or in-kind assistance to the patient

No alterations or redactions on documents allowed.

This information must be received within 30 days in order to process your application. Accounts eligible for Financial Assistance Review under WellStar Health System's Financial Assistance Program must have completed applications submitted within 240 days from the first post-discharge billing statement date. WellStar reserves the right to not process your account for the Financial Assistance Program, if non-compliant. You may contact WellStar with questions or for assistance with this application at:

SBO FAP Department, P.O. BOX 670747, Marietta, GA 30066, Fax number: 770-792-1737 or Phone number: 470-245-9998.

Comments:

I hereby request that WellStar determine my eligibility for its Financial Assistance Program. I understand that the information which I submit regarding my annual income and family size must be verified. I also understand that if the information I submit is determined to be false, such a determination will result in a denial of eligibility for Financial Assistance. I further agree to comply with the application and screening process for any assistance (i.e., Medicaid, Medicare, State Aid (for cancer), Vocational Rehab, Insurance, etc.) that may be available for payment of my WellStar account charges. I will fully cooperate in taking whatever actions may be deemed necessary to obtain such assistance and will assign or pay WellStar the amount recovered for WellStar charges. I agree to pay any balances remaining after Financial Assistance Program adjustment is made. Failure to do so may result in a reversal of any Financial Assistance Program discounts. A completed Financial Assistance Program application is applicable per guarantor.

I affirm that the above information is true and correct to the best of my knowledge.

Guarantor Signature: _____ Date: _____