WellStar Health System

Hospital Financial Assistance Program Application

LD-24-01 Job Aid 4.1A
(Rev. 7/16) WS Legacy

P.O Box 670747
Marietta, Georgia 30066
Phone: 770-792-1791

PATIENT INFORMATION U.S. Resident ◯ Yes ◯ No

Account Number: ____________ Corporate: ____________

Name: ____________ SS#: ____________ Birthdate: ____________

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

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's 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 claimed on your federal tax form.)

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

Have you applied for Medicaid?
Yes ◯ No ◯

Do you qualify for Cobra?
Yes ◯ No ◯

Assets and Other Income Sources

Checking Balance $ ______ Name of Bank: ____________ Savings Balance $ ______ Name of Bank: ____________

Monthly Pension $ ______ Social Security: $ ______ IRA $ ______ CD's $ ______ Child Support $ ______

Do you receive Student Loan Refunds? Yes or No (Circle One) Student Refunds $ ______

Alimony $ ______ Landowner: Yes or No (Circle one) Value $ ______ Any other assets, i.e. stocks, bonds, 401K $ ______

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? $ ______

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 any or all of the following that are applicable:**

Provide any or all of the following if unable to provide a copy of the most recent Federal Income Tax Return:

- ☐ Provide three (3) months of the most recent paycheck stubs or a statement from employer verifying gross wages; or
- ☐ IRS W-2 issued during the past year; or
- ☐ Most recent IRS Form 1040; or
- ☐ Most recent two (2) months of bank statements for each checking, savings, money market or other bank or investment account; or
- ☐ 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, alimony documentation, child support documentation, etc.); or
- ☐ Unemployment compensation denial letter; or
- ☐ Documentation of asset values, including, without limitation, property tax statements, Certificates of Deposit, 401k, 403b, IRA and other investment statements; or
- ☐ Contribution statements from individuals who contribute income or in-kind assistance to the patient

This information must be received in order to process your application. If you fail to be compliant in returning the above information within 240 days from the first post-discharge billing statement date, WellStar reserves the right to not process your account for Financial Assistance Program approval. You may contact WellStar with questions or for assistance with this application at:

SBO FAP Department, 805 Sandy Plains Road, Marietta, GA 30067 or our Phone number: 678-838-5750.

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 make application 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:** __________

______________________ __________