UNIVERSITY HOSPITAL
An Affiliate of University Health Care System

PLACE PATIENT LABEL CAREFULLY HERE

Indigent / Charity Care Program Declaration

Household Annual Income: _____ Status Code: [ ]

# of Persons Living In Home _____ Service Date: _____

Patient Name: Social Security #: Date of Birth

Address City State Zip Phone

_____ hereby apply for health care assistance under the University Indigent/Charity Care Program.
Print Name

My signature below denotes understanding and agreement to items 1-8 below:

1. I believe that my household does not have enough income or resources to pay the charges for the medical care I, or my child, needs.
2. I certify that the patient (myself or my child):
   a. Is a resident in the State of Georgia.
   b. Is not covered by any health insurance plan (Medicare, Medicaid, or private insurance).
   c. Is not receiving Cancer State Aide benefit.
   d. Is not eligible for Veteran's Administration medical care.
   e. Is not a member of the military member's dependent (s).
   f. Within the last three years, has not been convicted of welfare fraud, entered into a disqualification consent agreement, been determined at an administrative hearing to have committed an intentional welfare program violation, or to have waived a disqualification hearing with respect to a charge of welfare fraud or intentional program violation.
   g. Is not a college student who is covered under his / her parent's insurance coverage..
   h. Is a U S Citizen.
3. I also certify that the injury or illness for which I am asking Indigent Care Trust Fund support did not occur while at work, is not covered by worker's compensation, is not the result of an automobile accident, and is not covered by medical coverage due to an automobile accident or any pending lawsuit.
4. This authorizes employers, Social Security Administration, Veterans Administration, Department of Social Services, Family and Children Services (DFACS), and any other State or local agency to release benefits and payroll information for the purpose of determining my eligibility for health care assistance. I understand the information I provide may be verified for completeness and accuracy to include credit reviews with credit bureaus. I specifically authorize the Department of Labor to provide earnings information to DFACS.
5. I understand the Indigent/Charity Care Program is for University Hospital services only and not physician services.
6. Indigent eligibility will be determined by electronically available resources or Presumptive Eligibility Software that University Hospital may use to determine my financial ability. And that such determination/denial does not affect my ability to receive care for medically essential services at University Hospital.
7. I understand that University may need additional documentation than the presumptive eligibility software to determine my financial ability to pay and I will provide any supplemental data as requested.
8. I understand that if I fail to provide full and true information, my consideration for Indigent and Charity Care will be automatically denied and I may not be eligible to apply for financial assistance in the future.

_____ _____ _____
Signature Relationship to Patient Date/Time

Witness/Registrar _____

If approved, you will receive a letter stating that you have been approved for Indigent and Charity Care to cover only hospital services for a specific timeframe. During the review process, you may receive billing statements.

Patient Account No.: 1. _____ Patient Name(s): 1. _____

2. _____ 2. _____

3. _____ 3. _____

4. _____ 4. _____

UNIVERSITY HOSPITAL
TIME PAYMENT APPLICATION

PATIENT INFORMATION

Guarantor Name _____
LAST FIRST MIDDLE OR MAIDEN

Social Security # _____ Date of Birth _____ Phone ( ) _____

Home Address _____
NUMBER STREET APT. # CITY STATE ZIP

If less than 5 years previous address _____

❑ Employed ❑ Retired ❑ Disabled ❑ Unemployed ❑ Student ❑ Dependent

Effective_____ Effective _____ Effective _____ Effective _____ Effective_____ Effective. _____

Employer Name: _____ Date of Hire: _____

Employer's Address: _____ Employer's Phone: ( ) _____
NUMBER STREET

_____
CITY STATE ZIP

Occupation _____

Copies of last 3 paystubs must be submitted with this application for consideration

Total Monthly Income (+) $ _____

Other Income (Alimony, Child Support) (+) $ _____
(OPTIONAL)

SPOUSE/ADDITIONAL HOUSEHOLD WAGE EARNER

Spouse/Additional Household Wage Earner Name _____
LAST FIRST MIDDLE OR MAIDEN

Social Security # _____ Date of Birth _____ Phone ( ) _____

Home Address _____
NUMBER STREET APT. # CITY STATE ZIP

If less than 5 years previous address _____

❑ Employed ❑ Retired ❑ Disabled ❑ Unemployed ❑ Student ❑ Dependent

Effective_____ Effective _____ Effective _____ Effective _____ Effective_____ Effective. _____

Spouse's/Wage Earner's
Employer Name: _____ Date of Hire: _____

Employer's Address: _____ Employer's Phone: ( ) _____
NUMBER STREET

_____
CITY STATE ZIP

Occupation _____

Copies of last 3 paystubs must be submitted with this application for consideration

Total Monthly Income (+) $ _____

Other Income (Alimony, Child Support) (+) $ _____
(OPTIONAL)

**********PLEASE NOTE SPOUSE INFORMATION MUST BE PRESENT FOR CONSIDERATION**********

GENERAL INFORMATION

Dependent Information:	Name	Age	Relationship	Outstanding Accts. @ UH

Have you ever applied for Medicaid? ❑ Yes ❑ No Date: _____

If yes, reason for denial _____

Do you receive Food Stamps? ❑ Yes ❑ No Effective: _____

Continued on back

FINANCIAL INFORMATION

Bank _____ City, State _____

❑ Own Home Balance owed: $_____ Monthly payment (-) $ _____

Approximate value of Home: $_____

❑ Renting How long? _____ Monthly rent (-) $_____

Other property owned? ❑ Yes ❑ No Approximate value $_____

Description/Address _____

Is this rental property? ❑ Yes ❑ No

Amount of monthly rental income (+) $ _____

Automobiles owned:

Make _____ Model _____ Year _____ Monthly Payment (-) $ _____

Make _____ Model _____ Year _____ Monthly Payment (-) $ _____

Recreation vehicles owned (Boat, Camper, etc.): ❑ Yes ❑ No

Make _____ Model _____ Year _____ Monthly Payment (-) $ _____

Make _____ Model _____ Year _____ Monthly Payment (-) $ _____

LIST ALL DEBTS OWED NOT PREVIOUSLY LISTED ABOVE, IF NEEDED, ATTACH SEPARATE SHEET.
*******PLEASE INCLUDE ALL MEDICAL BILLS, CREDIT CARDS, DEPARTMENT STORE CHARGE CARDS,*******
INSURANCE PREMIUMS ETC.

To Whom Owed:	Balance	Monthly payment
_____	_____	(-) $ _____
_____	_____	(-) $ _____
_____	_____	(-) $ _____
_____	_____	(-) $ _____
_____	_____	(-) $ _____
_____	_____	(-) $ _____
_____	_____	(-) $ _____
_____	_____	(-) $ _____
_____	_____	(-) $ _____
_____	_____	(-) $ _____
	TOTAL:	(-) $ _____

Monthly household expenses: * Must include copy of last utility bill *

Food:	(-) $ _____
Electric:	(-) $ _____
Telephone:	(-) $ _____
Gas:	(-) $ _____
Sanitation:	(-) $ _____
Water:	(-) $ _____
Prescriptions:	(-) $ _____
Cable:	(-) $ _____
TOTAL:	(-) $ _____

Other Assets (Example: Certificates of Deposit, Stocks, etc.): Description_____ Value (+) $_____

Description_____ Value (+) $_____

I certify that the above information is true and correct. I authorize University Hospital to contact the employers and institutions on this application to verify its accuracy. I further authorize the employer/institutions to release such information to University Hospital. I understand that University Hospital will verify the completeness and accuracy of all information I have supplied herein and that my failure to provide full and true information will result in the automatic denial of my application.

_____ _____

GUARANTOR DATE

_____ _____

SPOUSE OR LEGAL GUARDIAN DATE

Application taken and verified by _____

*NOTE: *If the account balance if over $5,000.00, a copy of your last income tax return must be included.**