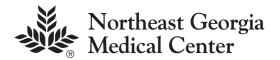


Charity / Indigent Care Application

	_Social Security Number:		rth:
Sex: I Male I Fe		Status: Married Single	Divorces Widowed
	pe of Health Insurance? Q Yes		
5	Medicaid Card? Yes No	Date Issued:	
Are you on Medicare? Yes No			
Are you on Social Security Disability with Medicare or Medicaid? Yes No			
Are your children on health insurance, Peach Care of Medicaid? Yes No			
Address:) (STREET)	(CITY)	(STATE) (ZIP)
	Cell Phone:		one:
Parent or Guardian if patient is under 21:			
	n) Employer:		
	ddress:		
	f-Employed?		
	·		
	ddress:		Phone:
Is Spouse Self-Employed? Yes No Type of work:			
Full Name of Spouse and/or Legal Dependents Living in Household under 21, DOB, and Relationship:			
			,
1(NAME)		(DOB)	(RELATIONSHIP)
2		(DOB)	(RELATIONSHIP)
3		(DOB)	(RELATIONSHIP)
(NAME)		(DOB)	(RELATIONSHIP)
4		(DOB)	(RELATIONSHIP)
5			
(NAME)		(DOB)	(RELATIONSHIP)
Savings Account Balance	Checking Account Balance	Real Estate Equity Value	Auto Equity Value
 I agree to provide application and he I understand that (e.g. Medicaid, Me The above write-or granted in connect been filed naming reversal of the chains I understand that and I understand 	orm has been examined by me and that Northeast Georgia Medical Center, Inc. ereby give permission for their agents to I must apply for any other benefits which edicare, County Hospitalization, Disabilit off is for your benefit only and based sole to with any third party liability, whether you as the injured party. Any money red arity write-off up to the amount of the red if I give false information that a charity ca that the hospital may obtain any credit h denied if application not completed and re	with any information needed to verify obtain such information directly on n might pay these accounts before ch y, etc.) In the disclosure in your application the liability arises by contact or negl covered by the Hospital as results of overy. are approval may be reversed and the istory.	y statements given in this hy behalf. larity care can be approved on. No release or write-off is igence. A hospital lien may have a hospital lien will result in a at Legal Action may be pursued,
Signature of Patien	t or Guardian:	Date:	Time:

Relationship to Patient: _____



The following information must be provided in order to process your charity/indigent care application:

- □ Proof of household income; last 4 most recent pay stubs. If self-employed, provide copy of recent federal income tax filed.
- If not married, but there are children in common, you must provide entire household income. If receiving child support or alimony this must also be provided.
- □ If you are still legally married but separated, you must provide legal documentation of separation or provide spouse income.
- □ If you lost your job within the last three months you are required to provide a separation letter from your past employer, and if you have no income at this time please provide a notarized, signed support letter from person who provides room and board for you and your family.
- □ If you have listed any child or children on your application other than biological or stepchildren, you must provide legal documentation to this effect.
- Proof of home address, such as: valid GA drivers license, GA ID or current utility bill. If you cannot provide any of the above, provide a notarized letter from your landlord stating your home address.

You are required to return all information within the next 15 days. This application is not a guarantee that your account will not follow our collection process. Your accounts will not be placed on hold.

You will receive an approval or denial letter upon completion of application review.

Sincerely, Financial Assistance (770) 219-7048