8340D

Memorial
HEALTH
University Medical Center

FINANCIAL ASSISTANCE SCREENING FORM

Date: _____

Dear Patient,

You may be eligible for assistance with charges from your recent hospital visit. **In order to assist you in completing the appropriate application(s), the following information must be received in our office within 14 days.**

***Our records do not contain any health insurance information. If you have Medicare, Medicaid, Tri-Care, Champus, PeachCare, or any type of medical/hospitalization insurance coverage, please contact the Billing Office immediately at (912) 350-8677 or (800) 682-4794.**

***Please complete the information below. Circle appropriate answers and fill in blanks to the best of your knowledge.**

PATIENT INFORMATION

Name: _____ Social Security #: ___-___-___ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Marital Status: M S D Separated Are you pregnant? Yes No

How many minor children do you have in physical custody? _____ Ages of children: _____

INCOME INFORMATION

Do you receive child support? Yes No If so, how much per month? $_____

Are you employed? Yes No Employer/Phone #: _____ Monthly Income: $ _____

Is your spouse employed? Yes No Employer/Phone #: _____ Monthly Income: $ _____

Do you receive a check from Social Security? Retirement Disability Survivors Amount? $ _____

Does your spouse receive a check from Social Security? Retirement Disability Survivors Amount? $ _____

Do your children receive a check from Social Security? Retirement Disability Survivors Amount? $ _____

Do you receive Unemployment Compensation? Yes No How much per month? $_____ How long? _____

Do you receive Workman's Compensation? Yes No How much per month? $_____ How long? _____

Do you pay rent? Yes No How much? $_____ Do you have a mortgage? Yes No How much? $ _____

MEDICAID INFORMATION

Have you applied for Medicaid? Yes No Where? _____ When? _____

Are your children on Medicaid? Yes No Name of Caseworker: _____ Phone: _____

Have you applied for PeachCare for your children? Yes No Date of Application? _____

ASSETS

Do you have any bank accounts in your name/spouse's name? Yes No

Please indicate balance next to appropriate account type:

Checking: $_____ Savings: $_____ CD: $_____ IRA: $ _____ Stocks/Bonds: $ _____

Please indicate any other assets that are in your name (for example, rental properties, 401K, other properties): _____

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LITIGATION:

Do you have a lawsuit pending? Yes No If yes, please explain: _____

Name of Attorney: _____ Attorney's Phone Number: _____

Attorney's Address: _____

ACCIDENT INFORMATION/EMPLOYMENT STATUS:

Were you injured in an accident? Yes No If yes, please give date and place of accident: _____

_____

Are you unable to work due to a medical condition? Yes No

If yes, please explain: _____

_____

When did this condition cause you to stop working? _____

Has a doctor told you to apply for disability benefits? Yes No Which doctor? _____

Have you applied for disability benefits? Yes No Where? _____ When? _____

If you have trouble completing this form, please contact 912-350-7828.

Once this form has been returned, it will be reviewed by our staff and if our department requires additional information or an additional application, you will be contacted.

Thank You,

Financial Assistance Department

Memorial Health University Medical Center, Inc.