Beaufort Memorial HOSPITAL

Instructions for Completing the Beaufort Memorial Hospital Financial Assistance Application

- For your convenience, check each box as the item is obtained and/or completed
- Please return this form with your application

Patient Name: ____ **Date:** ___________________

ALL APPLICANTS:

- ☐ Answer all questions completely. If the question does not apply to you, write not applicable or none.
- ☐ Sign and date the application

You must provide the following documents with this application

- ☐ Photo identification (drivers license, passport, immigration ID card, state issued ID card)
- ☐ Non-residents or undocumented visitors must provide proof of entry into the United Sates
- ☐ Proof of Gross Wages for past 3 pay periods (i.e. – pay stubs, last pay stub with year-to-date gross wages, signed statement from employer with gross wages)
- ☐ Other monthly income (i.e. – rental income, pension, annuities, child support)
- ☐ Complete copy of the most recent Income Tax Return
- ☐ Completed 4506-T form if taxes were not filed
- ☐ Direct deposit of Income – Attach most current 3 months of your bank statements that must show direct deposit income if applicable. (Social security checks, etc.)
  - Note – all deposits on bank statement will be considered income unless supporting documentation can be supplied listing deposits are loans.
- ☐ If you do not have any income, a letter of support will be required from the person(s) providing such support. This document must be notarized.

- ☐ **If you are Self Employed** submit 3 months of your gross business income & business expenses from your business ledger, the quarterly statement provided to your accountant or on business stationery signed and dated.

Name and Address of your Business

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APPLICATION FOR FINANCIAL ASSISTANCE

Applicant Name: ____________________________________ **Phone:** __________________________

Address: ____ **Cell:** ____________________________
Street

____ **Email:** ___________________________
City *State* *Zip*

Spouse/Domestic Partner: _____________________________ State of Residence: _______________

Is this application for services to be provided at a future date? ( ) Yes ( ) No
If yes, what is the service? ____
Who is the physician referring you for the service? _______________________

Does the applicant/patient have health insurance? ( ) Yes ( ) No
Is the applicant/patient employed? ( ) Yes ( ) No
Does the applicant/patient collect unemployment? ( ) Yes ( ) No
Is the patient age 65 or older? ( ) Yes ( ) No
Is the patient 19 years of age or younger? ( ) Yes ( ) No
Is the patient legally blind or disabled? ( ) Yes ( ) No

HOUSEHOLD INFORMATION

Total Number of Household Members: ______________

Name	Date of Birth	Relationship to Applicant	Health Insurance (Ex: Medicaid,Medicare, Other – Please Specify

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EMPLOYMENT HISTORY

List all employers during the last 3 months, beginning with the most current.

Applicant:
Employer: ________________________________ From: __________________ To: __________________
Employer: ________________________________ From: __________________ To: __________________
Employer: ________________________________ From: __________________ To: __________________

Spouse/Domestic Partner:
Employer: ________________________________ From: __________________ To: __________________
Employer: ________________________________ From: __________________ To: __________________
Employer: ________________________________ From: __________________ To: __________________

Other Household Member:
Employer: ________________________________ From: __________________ To: __________________
Employer: ________________________________ From: __________________ To: __________________
Employer: ________________________________ From: __________________ To: __________________

Other Household Member:
Employer: ________________________________ From: __________________ To: __________________
Employer: ________________________________ From: __________________ To: __________________
Employer: ________________________________ From: __________________ To: __________________

Other Household Member:
Employer: ________________________________ From: __________________ To: __________________
Employer: ________________________________ From: __________________ To: __________________
Employer: ________________________________ From: __________________ To: __________________

ASSETS

This form must be completed as part of the application for all household members

Bank/Credit Union Accounts: (savings, checking, IRAs, CD's, vacation or Christmas club, etc.)

Account Owner	Bank Name and Address	Account Number	Balance

Motor Vehicles

Automobile Owner	Make and Model	Model Year	Amount Owed

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ASSETS CONTINUED

Stocks/Bonds/Mutual Funds

Account Owner	Type of Stock/Bond	No. of Shares	Value

Real Estate

Home/Land Owner	Location/Address	Value of Property

Other Assets (Healthcare Savings Account, Flexible Spending Accounts, Whole Life Policies, etc.)

Description	Value

GROSS HOUSEHOLD INCOME

Sources of Income	Household Member	Amount	Frequency		
			Weekly	Bi Weekly	Monthly
Salary/Wages (Gross)					
Salary/Wages (Gross)					
Salary/Wages (Gross)					
Social Security					
Social Security					
Disability					
Child Support					
Alimony					
Unemployment					
Pensions					
Pensions					
Insurance/Annuity Payments					
Public Assistance/Food Stamps					
Veterans Payments					
Workers Comp Payments					
Other Payments					

Self Employment, Business, Rental Income:

Sources of Income	Household Member	Amount	Frequency		
			Weekly	Bi Weekly	Monthly
Business Income					
Business Expenses					
Net Business Income					

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MONTHLY EXPENSES

House/Rent $____________

Electric $____________

Water $____________

Phone/Cell $____________

Auto Payment $____________

Auto Payment $____________

Food $____________

Loans $____________

Credit Cards $____________

Child Support $____________

Alimony $____________

Other (____________) $____________

Other (____________) $____________

Other (____________) $____________

Insurance Premiums

House/Rental $____________

Automobile $____________

Health/Medical $____________

Life $____________

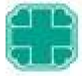
Total Monthly Expenses

$____________

Medical/Healthcare Expenses

Include physician, hospital and drug costs. Copies of bills must be included with application,

Provider/Entity	Amount



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If you reported no income above, please explain how you obtain housing, food, daily living essentials and who helps you pay for your basic needs: ____

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Briefly explain why you feel you are financially unable to pay your outstanding account balance at Beaufort Memorial Hospital: ____

____

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I certify that the information provided by me in this application is correct and true to the best of my knowledge. I understand that if I give false information or withhold information, assistance may be denied or reversed at the discretion of Beaufort Memorial Hospital. I also understand that each episode of service must be pre-approved. Incomplete applications will not be considered.

____ ______________________
Patient/Guarantor Signature Date

For Beaufort Memorial Staff Use:

MONTHLY SNAPSHOT

Total Income $____________

Total Assets $____________

Total Living Expenses $____________

Total Medical Expenses $____________

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