Hospital Authority of
MILLER COUNTY

Dear Patient,

Thank you for trusting the Hospital Authority of Miller County with your health care needs. This packet includes important information for you about how to get help with your hospital and medical bills. The Financial Assistance Program includes assistance with hospital and medical bills for applicants who qualify and includes applying for programs like indigent care, charity care, or Medicaid.

If you would like to apply for the Financial Assistance Program at the Hospital Authority of Miller County, please complete the attached application. In addition, we will need some supporting documentation to determine whether you qualify. The items listed below are the basic requirement; however, during the interview process it may be determined that additional information is required.

Verification of your household income:

- Last **three months** of check stubs (please see check stub breakdown below) or verification of wages on a company letterhead
  - If you are paid Weekly, please supply last 13 check stubs
  - If you are paid Semi-monthly or every two weeks, please supply last 7 check stubs
  - If you are paid Monthly, please supply last 3 check stubs
- Copies of Social Security checks or letter from the Social Security Office showing amount, and/or documentation of amount received from any other pension source
- Last year's tax return

Additional Information:

- Valid driver's license or state issued identification card with photo
- Food Stamp Letter, if applicable
- Any records demonstrating all child support due and received, if applicable
- Income of all household family unit members responsible for the patient's medical bills. The family unit consists of individuals living alone; and spouses, parents, and children under age 18 living in household.

Proof that you are a Georgia resident (please present one of the following):

- Utility Bill
- Telephone Bill
- Rent/Mortgage Receipt
- If you live with someone, please provide a letter from that person stating your residency and the amount of rent you pay.

Once you complete the application and have copies of all required supporting documentation, please return the enclosed application with copies of your supporting documentation to the hospital. You may also call our office at 229-758-3554 to schedule an appointment with a Financial Counselor to discuss your application. **If you choose to mail your application, please do not mail original versions of your supporting documents as any submitted documents will not be returned to you.**

Please be sure to have all the above information when you submit your application. If you do not have all the information, we cannot process your application. Please be aware that once we receive a complete application with all required supporting documentation, it will take up to five (5) business days to determine whether you qualify for financial assistance.

Financial Counselor
209 N. Cuthbert Street
Colquitt, GA 39837
Telephone (229) 758-3554
Fax (229) 758-5936

APPLICATION FOR FREE AND REDUCED-CHARGE SERVICES UNDER THE INDIGENT CARE TRUST FUND ICTF PROGRAM HOSPITAL AUTHORITY OF MILLER COUNTY

Patient Name: _____ **Date:** _____

Applicant Name *(if different from Patient Name)*: _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Telephone: _____ **Social Security Number:** _____ **DOB:** _____

Are You Employed *(please circle one)* YES NO **If No, are you retired?** YES NO

If Yes, are you full-time or part-time: Full-time Part-time

Employer Name and Address: _____

_____

_____

Do you currently have Health Insurance? YES NO

If Yes, Name of Insurance Company: _____ **Policy Number**: _____

Spouse Information ***(Please complete only if you are married)*:**

Name: _____ **DOB:** _____ **Social Security Number:** _____

Is Your Spouse Employed (please circle one) YES NO **If No, are you retired?** YES NO

If Yes, are you full-time or part-time: Full-time Part-time

Employer Name and Address: _____

_____

_____

Please list members of your household, birthdate, relationship to patient, and income from each source: please state whether income is per week, month, or year.

If income of any member is from self-employment, you may give information on business costs so that we can determine actual income to be counted. Write details on the back of this sheet.

Note to Applicant: You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills and would not have to be counted or report income).

NAME	DATE OF BIRTH	RELATIONSHIP	INCOME (WK/MO/YR)	INCOME (WK/MO/YR)	INCOME (WK/MO/YR)

Monthly Expenses:	Amount:
Rent/Mortgage	$
Auto Payment	$
Utilities	$
Phone	$
Total of Other Expenses (Please write details on back of this sheet):	$
Total Expenses:	**$**

Description of Assets	Amount
Savings Account Amount and Location:	$
Checking Account Amount and Location:	$
Savings Bonds and Location:	$
Cd's Amount and Location:	$
Retirement Funds:	$
Life Insurance Face Value Amount:	$
Rental Property:	$
Other Assets:	$
Total Assets:	$

Complete this section to enroll in the Medication Assistance Program. **PLEASE NOTE:** Eligibility for the Medication Assistance Program will be determined based on the provisions of the financial assistance program and is not guaranteed.

_____By initialing here, you wish to Opt-in the Medication Assistance Program. You agree to follow the guidelines of the medication assistance program. You agree to provide appropriate documentation and adhere to financial assistance program guidelines.

_____By initialing here, you wish to **DECLINE** the Medication Assistance Program. You understand that you have an option to receive medication assistance but decline. Please list reason if applicable_____.

Patient/Guarantor Signature: _____

HOSPITAL USE ONLY

Counted in HH: _____ Total Countable Income: $_____ Verification of Income Supplied? YES NO
(Average monthly income for last year or 3 months, whichever is more favorable)

Conditional Card Issued: YES NO Expiration Date: _____

Determination: Eligible for: FREE SERVICES DISCOUNT % _____ Eligibility Term: _____ to _____

Ineligible: _____ Reason: _____

Staff Signature: _____ Date: _____ Date Noticed Mailed: _____

Reconsideration Result: _____ Date: _____