Gwinnett Hospital System

FINANCIAL ASSESSMENT APPLICATION

If you think you may be eligible for financial assistance under the Federal Poverty Income Guidelines, please **complete this application and return it with the requested documentation listed below.**

NOTE: Financial assistance will not be considered without income proof and the completed application signed.

Provide all income verification listed below that applies to your Family Unit (applicant/patient, spouse/significant other and legal dependents).

1. Check stubs or statement from your employer indicating the last three (3) months gross income.
2. If self-employed, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.
3. Unemployment statement showing denial or eligibility and amount receiving.
4. Social security eligibility letter or a copy of your social security check. (If you have direct deposit, we will need a copy of your bank statement showing verification of this income.)
5. Previous year's signed income tax return can be accepted from January through March. Current year's tax return is accepted from April through December.
6. Proof of residency in Georgia. (Rental agreement, utility bill, property tax assessment notice.)
7. Proof of any other income source such as child support, alimony, trust funds, or rental property.
8. If you have not had any income for the last three (3) months, please send:
    a. A statement, signed and dated, explaining the circumstances surrounding your financial hardship.
    b. A notarized statement from the person(s) providing food and shelter.

Failure to submit the requested information may result in denial of your application because your financial eligibility could not be determined.

Phone: 678-312-4406
E-mail: financialcounselor@gwinnettmedicalcenter.org

Return application and income proof to:

Gwinnett Hospital System
P.O. Box 348
Lawrenceville, GA 30046
Attn: Financial Counselor

Approval under the Financial Assistance Program is effective for charges incurred from Gwinnett Hospital System only. The program does not cover physician charges such as Pathology, Cardiology, Radiology, Anesthesia, private physicians, ambulance or medication.

This program is not affiliated with any Medicaid or Medicare programs.

This application is valid for 90 days from your request for Financial Assistance.

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Patient Legal Name: _____ **Social Security #:** _____

Mailing Address: _____ City/State: _____ Zip: _____

Street Address (if different): _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Employer: _____ Occupation: _____ **Gross** Monthly Income $ _____

List members of Family Unit: (defined as applicant, spouse, and all legal dependents as allowed by the Federal Government)

Family Member Name	Birth Date	Sex	Relationship to Patient	Social Security Number	Employer / Hire Date	Gross Monthly Income
						$
						$
						$
						$
						$
						$

Other income source that you receive monthly:

Supplemental Security Income (SSI) $_____
Social Security Disability (SSDI) $_____
Unemployment $_____
Food Stamps $_____
Welfare (AFDC) $_____
Veteran's Benefits (VA) $_____
Pensions/Retirement benefits $_____
Child Support $_____
Interest/Dividends on Investments $_____
Other Income: $_____

Assets:
Savings account(s) $_____
Checking account(s) $_____
Stocks/bonds (market value) $_____
Face value of Certificate of Deposit(s) $_____
Recreational vehicles $_____
Cars/trucks $_____
Other assets: $_____

Household living expenses:

Mortgage or Rent:
1. Mortgage/rent monthly payment $_____
2. Property taxes/insurance $_____
3. Appraisal value of home $_____

Utilities: (water, garbage, electric, gas, cable, and phone/pagers) $_____
Food/Toiletries/Cosmetics: $_____
Total Automobile Payments:
1. Automobile payment $_____
2. Second automobile payment $_____
3. Auto fuel $_____
4. Auto insurance $_____
5. Auto repair expense $_____

Credit Cards: $_____
Loans: $_____
Insurance Premiums:
1. Life $_____
2. Medical $_____

Healthcare Expenses:
1. Medical bills $_____
2. Dental bills $_____
3. Prescriptions $_____

Child Care Expenses: $_____
Other Expenses: $_____

I certify that the information given on this form is true and complete to the best of my knowledge and that it is for the purpose of evaluating my financial condition and ability to pay any bills or charges for hospital services that I have received from Gwinnett Hospital System or any accounts which I have signed as Guarantor. I authorize my employer to release information regarding my income which may be necessary in evaluating my financial needs. I agree to promptly notify Gwinnett Hospital System of any changes in financial status affecting my ability to pay. By requesting financial assistance, I understand Gwinnett Hospital System may inquire into my (our) credit history.

Signature: _____ Date: _____

Signature of Spouse: _____ Date: _____
(If married, spouse signature required)