Hospital Financial Assistance Program Application
P.O. Box 748733
Atlanta, Georgia 30374
Phone: 470-245-9998

PATIENT INFORMATION U.S. Resident: ⬭ Yes ⬭ No

Medical Record Number (MRN):: _____ Facility Name: _____

Patient Name: _____ SS#: _____ Birthdate: _____

GUARANTOR and SPOUSE Information Married ⬭ Divorced ⬭ Separated ⬭ Widow ⬭ Single ⬭

Guarantor Name: _____ SS#:_____Relationship to Patient: _____

Birthdate:____/____/____ Home Address: _____

Phone #: (_____)_____ Other Phone: (_____)_____

Employer 1: _____Address:_____

Work #:_____ Position: _____Annual or Hourly Pay: _____ Working Full time, Part time, or Unemployed (circle one)

Employer 2: _____Address:_____

Work #:_____ Position: _____Annual or Hourly Pay: _____ Working Full time, Part time, or Unemployed (circle one)

Spouse's Name: _____ SS#: _____Birthdate:____/____/____

Employer 1: _____Address:_____

Work #:_____ Position: _____Annual or Hourly Pay: _____ Working Full time, Part time, or Unemployed (circle one)

Employer 2: _____Address:_____

Work #:_____ Position: _____Annual or Hourly Pay: _____ Working Full time, Part time, or Unemployed (circle one)

Legal Dependents (List only those dependents that can be claimed on your federal tax form)

Name (First, Middle, Last)	Birthdate (mm/dd/yy)	Relationship	
	/ /		Have you applied for Medicaid? Yes _____ No_____
	/ /		
	/ /		Do you qualify for Cobra?
	/ /		
	/ /		Yes_____ No_____

Assets and Other Income Sources

Checking Balance: $_____Bank Name: _____Savings Balance: $ _____Bank Name: _____

Money Market Balance: $_____Bank Name: _____ Social Security: $_____Monthly Pension:$_____

Alimony: $_____Child Support: $_____ CDs: _____

Any other assets, i.e. stocks, bonds, etc.: Type: _____ Value ($):_____

Do you receive Student Loan Refunds? Yes or No (Circle One) Student Refunds Amount: $ _____

Have you filed for bankruptcy in the past 3 years? Yes or No (Circle One) If yes, provide the date: ____/____/____

Do you own any rental property? Yes or No (Circle One) If yes, what is the monthly income? $_____ Property's Value: $_____

Wellstar Health System is committed to providing financial assistance to patients who have sought medically necessary care at Wellstar Hospitals but have limited or no means to pay for that care. Wellstar will provide emergency medical care to all individuals, regardless of their ability to pay or eligibility under its Financial Assistance Program.

In order to qualify for financial assistance for Wellstar hospital, cooperation with Wellstar is necessary in identifying and determining alternative sources of payment or coverage from public and private payment programs. In order to qualify for financial assistance, the following is necessary:

Application information:
Submit a true, accurate, signed and completed application for financial assistance; and
all applicants for Financial Assistance must provide proof of Household Income and Household Assets by providing the following that are applicable:

Most recent Internal Revenue Service (IRS) Form 1040 AND IRS W-2/1099 (if applicable) issued during the past year to match IRS Form 1040

Provide the following documents based on CURRENT financial situation:

- ☐ Provide three (3) months of the most recent paycheck stubs or a statement from employer verifying gross wages AND the most recent two (2) months of bank statements for each checking, savings, money market or other bank or investment account for the household. All pages including blank pages. OR
- ☐ Most recent IRS Form 1040 (Including all schedules) AND IRS W-2/1099 (if applicable) issued during the past year to match IRS Form 1040.

Additional Documentation (if applicable)

- ☐ Written statements for the most recent two (2) months for all other income (e.g., unemployment compensation, disability, retirement, student loans, award letter from Social Security Office, current Profit and Loss report for all self-employed applicants, court ordered alimony documentation, court ordered child support documentation, or Benefit Card Activity Statement (TANF), etc. for the household)
- ☐ If Unemployed less than 3 months--Separation Notification from Previous Employer
- ☐ If Unemployed more than 3 months--Wage Inquiry (Department of Labor)
- ☐ Unemployment compensation denial letter
- ☐ Documentation of asset values, including, without limitation, property tax statements, Certificates of Deposit, and other investment statements
- ☐ Contribution statements from individuals who contribute income or in-kind assistance to the patient.
- ☐ No alterations or redactions on documents allowed.

This information must be received within 30 days in order to process your application. Accounts eligible for Financial Assistance Review under Wellstar Health System's Financial Assistance Program must have completed applications submitted within 240 days from the first post-discharge billing statement date. Wellstar reserves the right to not process your account for the Financial Assistance Program, if non-compliant. You may contact Wellstar with questions or for assistance with this application at:

Single Billing Office (SBO) Financial Assistance Program (FAP) Department, P.O. BOX 748733 Atlanta, GA 30374, , Fax number: 770-792-1737 or Phone number: 470-245-9998

Comments:

I hereby request that Wellstar determine my eligibility for its Financial Assistance Program. I understand that the information which I submit regarding my annual income and family size must be verified. I also understand that if the information I submit is determined to be false, such a determination will result in a denial of eligibility for Financial Assistance. I further agree to comply with the application and screening process for any assistance (i.e., Medicaid, Medicare, State Aid (for cancer), Vocational Rehab, Insurance, etc.) that may be available for payment of my Wellstar account charges. I will fully cooperate in taking whatever actions may be deemed necessary to obtain such assistance and will assign or pay Wellstar the amount recovered for Wellstar charges. I agree to pay any balances remaining after Financial Assistance Program adjustment is made. Failure to do so may result in a reversal of any Financial Assistance Program discounts. A completed Financial Assistance Program application is applicable per guarantor.

I affirm that the above information is true and correct to the best of my knowledge.

Guarantor Signature: _____ Date: _____

Scenarios and additional documents acceptable in lieu of requested documents:

- If the current year income is less than income on the tax return than please provide two months of bank statements (no pages omitted) and 3 months' pay stubs instead of the tax return

  Provide two of the following if unable to provide a copy of the most recent Federal Income Tax Return, including all W-2's, 1099's and any schedules:
  - Provide three (3) months of the most recent pay stubs (or certification of unemployment) AND provide two (2) current bank statements for all checking, savings, money market accounts (no pages omitted).
  - If there are additional deposits in the bank account, we will need supporting documentation for those deposits.
    - For gifted or borrowed money, a letter from the person who gifted the amount or lender.
    - For inheritance, the probate letter that supports the amount.
    - For IRA, 401k, or other retirement distributions, or stocks/bonds sales, a statement from that account to verify the amount distributed.
    - For life insurance loans, a statement from that account showing the distribution.
    - For the sale of a car, a copy of the bill of sale.
    - For child support, a copy of the divorce decree showing the ordered child support.
    - For a job that does not provide pay stubs, a letter from the employer (even if it is a friend or family member) stating the amount of pay and the frequency of pay.
  - If you do not have any income in the past 3 months, a letter of support from the person who is helping you as well as a Wage Inquiry from the Department of Labor if you have a social security number.

- Other Situations:
  - A patient is a parent living with children and children are claiming the parent on their tax return.
    - Please provide your bank statements, employment pay stubs and support letter.
  - A patient is homeless.
    - Please provide the wage Inquiry or
    - If you are paid in cash, then we need your statement of income and a support letter from the person you are living with.
  - Patient/Applicant is under the age of twenty-one and listed as dependent on someone else's tax return.
    - Please provide the tax return, W-2's, 1099's, including all schedules for your parents.
    - If the parents did not file taxes, please provide the parents bank statements and pay stubs.