ABBEVILLE AREA MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

Name: _____ Phone #: _____

Address: _____ Date:_____

_____

List each member of the household, INCLUDING the patient.

Name (Include Patient)	DOB	SS#	Current Year Income	Previous Year Income	Source of Income	Relationship to Patient

As an uninsured patient, the SCDHHS requires us to inform you of possible health coverage options. They are listed below:

Explained to Me	**Applied For**	
❑	❑	**Medicare**
❑	❑	**South Carolina Health Connections Medicaid Program**
❑	❑	**Subsidized Health Insurance at the Federal Marketplace(Exchange)**
❑	❑	**Employer-Sponsored Health Insurance**
❑	❑	**Privately Purchased Health Insurance**

I acknowledge that all of the information provided is accurate and complete to the best of my knowledge and ability. I understand that no determination or approval will be made until incomplete or missing information is provided or actions required by me are completed.
This application and any approval for financial assistance are valid only for the calendar month in which it is made.
I authorize Abbeville Area Medical Center to take action(s) as necessary (including conducting a check of my credit history) to verify the accuracy of the information provided on this application.

Applicant Signature_____Date_____

Financial Counselor Signature_____Date_____