ABBEVILLE AREA MEDICAL CENTER

An Affiliate of Self Regional Healthcare

Financial Assistance Application Submission Directions

There are two convenient ways to submit your Medical Financial Assistance Program application.

1. **Return** the completed application along with all required documents to:

   Patient Financial Assistance Coordinator
   Abbeville Area Healthcare Center
   901 W. Greenwood St. Suite 1 in Abbeville

   After Hours Drop Off:
   Community Resource Center
   901 W. Greenwood St. Suite 8 in Abbeville

   Patient Financial Assistance Coordinator Business Hours
   Tuesdays 1:15pm-4:30pm
   Wednesdays 8:30am-12:00pm

2. **Mail** your completed application along with all required documents to:

   AAMC Community Resource Center
   Attention: Patient Financial Assistance Coordinator
   PO Box 887
   Abbeville, SC 29620

Questions?

Call 864-366-9681. If no one is available, leave a message and your call will be returned during the Patient Financial Assistance Coordinator's regular business hours.

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Required Medical Financial Assistance Application Documents

Needed documents for application process: This applies to all members living in the household with the applicant:

Please bring a copy of all that apply:

1. Social Security cards for all family members living in the household.
2. Birth certificates on all children under the age of 18.
3. Picture ID for all household adults.
4. Proof of gross income, most recent consecutive check stubs (8 if paid weekly, 4 if paid bi-weekly or two if paid monthly)
5. All bank or other financial account statements for the prior month showing beginning and ending balance (401K, 403B, IRA etc.) if applicable.
6. Federal income tax return for household.
7. Medical/life insurance policies or cards (if they have cash value)
8. Proof of application for unemployment
9. Print out from DSS stating what benefits your family receives, if any. If you do not receive benefits, a printout stating, “No Benefits Received.”
10. If you have any medical insurance, we will need a copy of your card front and back.

If you have questions, please contact our Financial Assistance Coordinator (FAC) on 864-366-9681. If the FAC is unavailable, you will receive a return phone call during normal business hours which are Tuesdays 1:15pm-4:30pm and Wednesdays 8:30am-12:00pm.

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Financial Assistance Application

1. Patient Information

Patient Name: _____ Medical Record Number: _____ Date of Birth: _____

Date of Application: _____ *If the patient is a minor, please list parent/guardian as applicant

2. APPLICANT (GUARANTOR) INFORMATION

Name: _____

Social Security Number: _____

U.S. Citizen? ☐ YES ☐ NO

RELATIONSHIP TO PATIENT

☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

MARITAL STATUS

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Birth: _____ Number of Dependents: _____ Home Phone Number: _____

Cell Phone Number: _____ Address (NO P.O. Boxes): _____

Name of Employer: _____ Employer Address: _____

If not working, how long have you been unemployed: _____

3. FINANCIAL ASSISTANCE QUESTIONS (all answers pertain to the patient)

1. Is the patient applying for assistance with bills for past services at Abbeville Area Medical Center or Self Regional Healthcare? ☐ Yes ☐ NO

If yes, please indicate the last service date: _____ Which facility: _____

2. Does the patient have health insurance? ☐ Yes ☐ NO

If yes, please provide the following:

Health Insurance name: _____ Subscriber Name: _____

Members/Patients Identification number: _____ Group Number: _____

Group/Employer Name: _____ Effective Date: _____

Health Insurance Telephone Number: _____

3. Is the patient eligible for any Federal medical assistance program? (i.e. V.A., Black Lung, etc.) ☐ Yes ☐ NO

If yes, please provide the following information

Name of program: _____ Program Telephone Number: _____

Patient Identification Number: _____

4. Is the patient being treated for injuries covered by Worker's Compensation? ☐ Yes ☐ NO

If yes, please provide the following information:

Name of Work Comp Carrier: _____ Adjusters Name: _____

Adjuster Phone Number: _____ Injury Date: _____

Claim/Case Number: _____

5. Is the patient being treated for injures covered by Third Party Liability such as an Auto Insurance Company? ☐ Yes ☐ NO

If yes, please provide the following information:

Name of Auto Insurance or Attorney: _____ Injury Date: _____

Name of Auto Insurance or Attorney Phone Number: _____ Claim/Case Number: _____

6. Is the patient a Victim of Crime? ☐ Yes ☐ NO

If yes, please provide the following information:

Name of Case Worker: _____ Date of injury: _____

Case Worker's Phone Number: _____ Case Number: _____

7a. Is the patient 65 or older (without Medicare)? ☐ Yes ☐ NO

If yes, please give a brief explanation why the patient does not have Medicare:

7b. Is the patient under 18? ☐ Yes ☐ NO

8. Is the patient pregnant? ☐ Yes ☐ NO

9. Does the patient have a diagnosis related to the following (check all that apply)? ☐ Yes ☐ NO

☐ Stroke ☐ Chronic Heart Disease ☐ Dialysis ☐ Cancer

10. Has the patient or guarantor had a recent event that would qualify for COBRA benefits (check all that apply)**?** ☐ Yes ☐ NO

☐ Employment change resulting in loss of job or reduction in hours

☐ Change in marital status resulting in the loss of benefits

☐ Spouse change insurance coverage due to Medicare coverage

☐ Death of a spouse

4. Family Members

Family Member Name	Relationship to Applicant	Date of Birth	Marital Status

5. Income (most recent consecutive check stubs (8 if paid weekly, 4 if paid bi-weekly or two if paid monthly))

Income Type	Family Member Name:	Family Member Name:	Family Member Name:	Family Member Name:
Employment Income	$	$	$	$
Disability	$	$	$	$
Unemployment	$	$	$	$
Investment Income	$	$	$	$

Workers Compensation	$	$	$	$
Social Security	$	$	$	$
Self Employment	$	$	$	$
Spousal/Child Support	$	$	$	$
Pension/Retirement	$	$	$	$
Veteran's Benefits	$	$	$	$
Other (write below):	$	$	$	$
Other (write below):	$	$	$	$

6. List any assets for family members (Checking/Saving Account, Cash on hand, US Saving Bonds, Stocks, Trust Funds, Certificates of Deposit, Face Value of Life Insurance, IRA/Pension Fund, etc...)

Family Member Name	Type of Asset	Name of Bank	Account Number	Cash/Value
				$
				$
				$
				$
				$
				$
				$
				$

7. List any resources that have been sold, deeded or given as a gift in the past three months

Owner	Resource	Account Number	Cash/Value
			$
			$
			$
			$
			$

8. Monthly Expenses for Family Members. If you need more room use the back of this page.

Expense Type	Family Member Name:	Family Member Name:	Family Member Name:	Family Member Name:
House/Mortgage Payment	$	$	$	$
Automobile Expense	$	$	$	$
Credit Cards	$	$	$	$
Child/Spouse Support or Alimony	$	$	$	$
Food/Groceries	$	$	$	$
Liens/Wage Garnishments	$	$	$	$
Other (write below):	$	$	$	$
Other (write below):	$	$	$	$

9. Comments (write any additional comments below that you wish us to review)

10. SIGNATURE

I certify that all information is valid and complete and hereby authorize Abbeville Area Medical Center and/or Self Regional Healthcare to request a credit check report and/or verify any of the above information as deemed necessary.

APPLICANT SIGNATURE _____ DATE _____

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No Income Form

NOTE: USE THIS FORM ONLY IF NO ONE IN THE HOUSEHOLD HAS INCOME
Patient must complete SECTION 1 - Person helping the patient must complete SECTION 2
Completed form must be submitted with AHL application package

SECTION 1 - Patient Information (All information required)

By signing, I verify that **I, OR NO ONE LIVING IN MY HOUSE** have no income. If I, or anyone in my house receives Food Stamps and/or help from the Housing Authority (HUD), **I HAVE ATTACHED A CURRENT STATEMENT FROM EACH ORGANIZATION.**

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

SECTION 2 - Person helping patient (All sections must be completed, including dollar amounts.) We need to know how patient is living day to day (housing, food, and utilities).

By my signature, I verify the above patient's current housing situation, that all information is true, and that no work or services are given in exchange for support. THE PERSON HELPING THE PATIENT CANNOT LIVE IN THE SAME HOUSE AS THE PATIENT.

Name of person helping or verifying patient living situation: _____
(Printed name)

Please list the dollar amount you have paid/given in the last 30 days for each item below that applies:

$_____House/Rent (If answer is $0 state why):_____
$_____Food (If answer is $0 state why):_____
$_____Utilities (If answer is $0 state why): _____
$_____Total amount given to patient per month

_____ Date: _____
(Signature of person helping or verifying patient living situation)

OR – Patient has no one over age 18 to vouch for their current living situation:
_____ Date: _____
(Patient Financial Assistance Coordinator