



PATIENT NAME: _____

ACCT#: _____

TODAY'S DATE: _____ APPLICATION DUE: _____

Return all documentation that applies to all members of your HOUSEHOLD:

- _____ Signed Acknowledgement of Charity Disclaimer
- _____ Social Security Card with correct name and/or current Alabama driver's License.
- _____ Most recent year's Income Tax Return (completed return-we do not accept W2 only) for all members of the household. If you did not file not a tax return, we will need a T4506-T form.
- _____ Food Stamp monthly allotment verification. The letter can be picked up at the Food Stamp Office.
- _____ Proof of unemployment benefits, which must have the maximum benefits listed.
- _____ Social Security/SSI Original Award letter, if applicable.
- _____ Proof of Social Security/Disability Income, if applicable.
- _____ Proof of Child Support and/or Alimony received.
- _____ Most recent bank statement.
- _____ Proof of any other sources of support being provided by family or friends. This must include the approximate dollar amount per month and must be notarized.
- _____ Three most recent pay stubs for all household members earning income and/or at notarized statement from the employer if you do not receive paystubs.
- _____ Copy of all recent bills reported, such as:

_____ Mortgage/Rent	_____ Home Owners Insurance	_____ Car Payments
_____ Car Insurance	_____ Health & Life Insurance	_____ Medical Bills
_____ Pharmacy Bills	_____ Credit Card Statements	_____ Loan Statements

Return the application and documentation to our office. We will make copies if needed.
If mailing, please send copies only. We will not be responsible for original documents.
Additional documentation may be required depending on individual situations
If you have any questions please contact one of the Counselors at 256-737-2677 or 256-737-2678.

DISCLAIMER: Our determination of approval for assistance is not necessarily taken into consideration by other providers. Please contact other providers directly for information regarding any bills you may have with them.

FINANCIAL ASSESSMENT APPLICATION

Patient's Name _____ DOB ___/___/___ SSN: _____

Sex: ___M___F Martial Status: S M W D

Guarantor's Name _____ DOB ___/___/___ SSN: _____

Sex: ___M___F Relationship to Patient _____

Current Address _____ City _____ State _____

Zip Code _____ County _____ Own/Rent _____ How Long? _____

Home Phone # _____ Cell # _____ Work # _____

Number of people in the household _____ Number of people who are working _____

Patient's Employer _____ How Long? _____

Spouse's Employer _____ How Long? _____

Do either employer(s) offer health insurance? (circle) Yes No

Have you recently lost insurance coverage from a former employer? (circle) Yes No

If yes, is it possible you are eligible under COBRA? (circle) Yes No

Have you applied for insurance under the Affordable Care Act? (circle) Yes No

Cost of Coverage per month: Family \$ _____ Single \$ _____

If unemployed, how long? _____ Do you receive unemployment check? _____

If spouse unemployed, how long? _____ Do they receive unemployment check? _____

Name of Bank _____ Do you have? checking ___ savings ___

Do you receive Child support? Yes No Alimony? Yes No How much? _____

Have you ever applied for SSI/Disability? Yes No When did you last apply? _____

Is the case? Pending ___ Denied ___ Approved ___

If pending or denied, are you represented by an attorney? Yes ___ No ___

Was this visit accident related? _____ If yes, was liability insurance involved? _____

If yes for liability insurance, provide name/phone number/address/policy information of insurance: _____

Requesting assistance for: _____ Prior Service Date _____ Future Service Date

Updated 08-19-2016

Permission to Release Information to the Good Samaritan Health Clinic

If you are uninsured, a resident of Cullman County and between the ages of 19 and 65, you may be eligible for healthcare services through Good Samaritan Health Clinic. Much of the paperwork required to qualify for the hospital's Charity Program is very similar to paperwork needed by the GSC. In an effort to speed up the application process the hospital will, with your permission, provide the GSC with copies of the documentation you have provided us.

I _____ attest that I am a resident of Cullman County and authorize Cullman Regional Medical Center to release financial information I have provided to CRMC as part of my charity application to the Good Samaritan Health Clinic. Any information not to be provided has been designated as such.

Signature _____ Date _____

Print Name: _____

Witnessed By: _____