## FLOYD MEDICAL CENTER – POLK MEDICAL CENTER – FLOYD CHEROKEE MEDICAL CENTER
## INCOME BASED HOSPITAL ASSISTANCE PROGRAM APPLICATION

Eligibility is based on household size, gross household income, asset value and liability. In order to determine eligibility, please complete and return this form to a Financial Counselor within 14 days along with **proof of current income, last year's tax return/1040, and most recent bank statement.**

Patient Name: ____________________________________________ Account number ______________________

**LIST *ALL* MEMBERS OF THE HOUSEHOLD, DATES OF BIRTH, RELATIONSHIP TO PATIENT AND INCOME FOR EACH PERSON. INDICATE WHETHER INCOME IS WEEKLY (WK), BI-WEEKLY, SEMI-MONTHLY, MONTHLY (MO) OR YEARLY (YR)**

| **NAME** | **BIRTHDATE** | **RELATIONSHIP** | **GROSS INCOME/**WK, MO, YR, etc. | **INCOME SOURCE** (SSI, Social Security, Unemployment, Wages, Child Support, Alimony, Odd Jobs and self-employment, etc.) |
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| | | PATIENT | | |
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If income for any member is from self-employment, you may give information on business costs so that we can determine actual income to be counted. Verification of circumstance may be requested. Income Tax Returns will be required to include children 18 years old or older or other dependent adults.

If you reported zero income, how are your needs being met? ____________________________________________________

Have you applied for or plan to apply for any insurance benefits including Medicare or Medicaid? Yes ☐ No ☐
Do you have a claim pending at this time with Medicare, Medicaid or Disability? Yes ☐ No ☐

Did you file income taxes for the past year? Yes ☐ No ☐
When did you last work? ___________(Approximate date) Last employer? ______________________________________

Do you own the home where you currently reside? Yes ☐ No ☐ Estimated Value of property: $_______________________
Do you own property, other than your home, or where you currently reside? Yes ☐ No ☐ Value of property: $_____________
Do you own a vehicle? Yes ☐ No ☐ Estimated Value: $_________
Do you own additional vehicles? Yes ☐ No ☐ If yes, Type of vehicle(s) and Estimated Value(s): _______________________

Total amount owed on all the assets listed above: $______________________
What is the total monthly payment amount you owed on the assets listed above? $_____________________________________
Do you have a cash reserve? Yes ☐ No ☐ Estimated amount $_____________________________________________________
Do you have a checking account? Yes ☐ No ☐ Balance ______________________________________________________
Do you have a savings account? Yes ☐ No ☐ Estimated balance _____________________________________________
Do you have a retirement account of any kind? Yes ☐ No ☐ Estimated balance:______________________
Do you own stock or bonds? Yes ☐ No ☐ Estimated Value: _____________________________________
Do you own a Certificate of Deposit? Yes ☐ No ☐ Estimated Value:_____________________________________
Have you inherited or won any property or money or received any lump sum payments during the last year?
Yes ☐ No ☐ Estimated Current Market Value: _______________________________

_____________________________________________________________ _________________

**PATIENT OR REPRESENTATIVE SIGNATURE** **DATE**

**Please note**: This transaction affects only Floyd Medical Center/Polk Medical Center /Cherokee Medical Center bills. A determination of eligibility for financial assistance based upon this application for the account listed above is final and is not subject to any subsequent reviews for changes in eligibility. If you received services from physicians not employed by this hospital (this includes the Emergency Room doctor), you may receive bills for treatment they provided.

Financial Counseling office hours are Monday through Friday, 8:00 AM 5:00PM
Floyd Phone 706-509-6940, Fax 706-509-6941;
Polk Phone 770-749-4284, Fax 770-749-4128
Cherokee Phone 256-927-1315, Fax 256-927-1416

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