HIGHLANDS MEDICAL CENTER

Financial Counselor

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380 Woods Cove Road
Scottsboro, Alabama, 35768

Financial Assistance Program OR Reduced Pay Plan Application

( ) Highlands Medical Center **( ) Highlands Ambulance Service**

Date of Application: _____

PLEASE READ

THIS APPLICATION MUST BE COMPLETED, SIGNED, DATED, AND RETURNED TO US WITHIN 30 DAYS OF VISIT FOR A FINAL DECISION ON YOUR ELIGIBILITY. THIS APPLICATION IS FOR HOSPITAL AND/OR AMBULANCE SERVICES ONLY AND DOES NOT INCLUDE ANY OTHER BILLS YOU MAY INCUR WHILE AT OUR FACILITY.

***** REQUIRED DOCUMENTS *****

- W-2 IRS FORM PRIOR YEAR FILED
- ALL HOUSEHOLD INCOME FOR THE PAST 2 MONTHS
- BANK STATEMENTS FOR LAST 2 MONTHS
- SOCIAL SECURITY DETERMINATION LETTER
- UNEMPLOYMENT DETERMINATION LETTER
- FOODSTAMP AWARD LETTER
- LAST ELECTRIC BILL
- RENT OR MORTGAGE RECEIPT
- AUTO LOAN RECEIPT

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Financial Statement

Please print and do not leave any lines blank. Print "N/A" in areas that do not apply to your circumstances.

Patient Name: Last		First		MI	
Account Number(s):					
Admission Date(s):		Reason:			
Social Security #:	DOB:	Age:		Male	Female
Marital Status (circle one) Married Common-law married Single Widowed Divorced Separated How long?					
Spouse's Name:		Spouse's Social Security #:			
Patient Home #:	Work #:	Cell #:			
Current Address:					
	Street	City	State	Zip	
County:		How long at current address:			
Name of relative not living in your household:		Phone # of relative:			
Patient Employer:		Hire Date: (month/day/year)			
If unemployed – last date worked (month/day/year)		Reason:			

List **ALL** Bank Accounts (Name and Account #s)

Account Name	Account #	Checking	Savings	Other

Property Owned House		Land	Auto (year and make)	
Are you Renting	Buying	Own	Living with and/or supported by someone?	Who?
Number of people living in household:		Relation to you?		
List the ages of **YOUR** children still living in the household:				
Was this an accident?	Nature of accident	Date and place accident occurred		
Medical pay policy info:	Liability policy info:	Homeowners policy info:		
Have you ever applied for SSI/Social Security Disability?		Date of last SSI application:		
Is the case still open and pending a decision?		If denied, have you filed an appeal?		
Do you have an attorney working on your case? Attorney Name:		Attorney's Phone # and Address:		

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Income and Expenses

MONTHLY INCOME

MONTHLY EXPENSES

*If expenses are shared, please list **your** portion only

Income Type	Amount	Expense Type	Amount
Gross wages/unemployment (patient)		Rent, house, or trailer payment	
Net wages after taxes (patient)		Land/lot payment	
Gross wages (spouse)		Utilities / Gas / Water	
Net wages after taxes (spouse)		Food / Phone Bill	
Gross wages/salary (parents)		Car payment / Car Insurance	
Net wages after taxes (parents)		Car payment / Car Insurance	
*If patient is a child, list income for both parents)		Child support/alimony payment	
Social Security check amount (patient)		Daycare/childcare expense	
Social Security check amount (spouse)		Education/college loans	
Social Security check amount (child)		List all insurance premiums paid:	
SSI Income (list amount & recipient)		Hospital/daily indemnity	
Military/Reserves/VA income		House/renters insurance	
Short/long term disability income		Health insurance	
Child support/alimony received		Student insurance	
Unemployment check amount		Life/burial insurance	
Retirement/pension check amount		Cancer insurance	
Workman's Compensation		Doctor and medical expenses (monthly)	
Rental income received		Prescription costs (out of pocket)	
AFDC/Family Assistance		Credit Card Name:	
Food Stamps received		Credit Card Name:	
Church assistance received		Credit Card Name:	
Other income or money received		Other expense	

Applicant's statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge and that no pertinent items of information have been concealed or omitted from this application. I also understand that Huntsville Hospital has the right to reverse their decision concerning charity discounts when discovery of information is made that indicates the patient/guarantors has or had the ability to pay for their services. I am giving Huntsville Hospital; permission to access my credit file and to provide my financial information to those companies contracted by Huntsville Hospital for the purpose of financial or product recovery programs for which I may qualify. If there is anyone you would like to allow us permission to speak with in regard to completing the financial application process, please list them below as a designated person in the space provided.

DESIGNATED PERSON

PATIENT'S INITIALS TO APPROVE

PATIENT /FAMILY REPRESENTATIVE SIGNATURE

DATE

SPOUSE'S SIGNATURE

DATE

MEDASSIST REP

FINANCIAL COUNSELOR

HIGHLANDS MEDICAL CENTER

Income and Expenses

IF ALL DOCUMENTS ARE NOT RETURNED THIS APPLICATION WILL BE DENIED

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital. The Hospital reserves the right to pull a copy of my credit report.

Signature of Applicant_____ **Date:** _____

Office Use Only:

Hospital Rep Reviewing App: _____**Date:** _____

Yearly Income $_____ **Charity Guidelines** $_____

Over/Under $_____

Approved? ( ) YES ( ) NO

Remarks_____

Dates Reviewed:

Account #	DOS:	Amount: $	Approved: ?	Date Approved/Denied	Reviewed by: