



Beaufort Memorial
HOSPITAL



affiliated with
Duke University
Health System
in Heart and Cancer

FINANCIAL ASSISTANCE APPLICATION

Complete this form and mail to
BEAUFORT MEMORIAL HOSPITAL
ATTN: FINANCIAL ASSISTANCE
955 RIBAUT ROAD
BEAUFORT, SC 29902

DATE: _____

NAME: _____

GUARANTOR ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NAME OF PATIENT: _____

ACCOUNT #: _____

GUARANTOR SS #: _____

DATE OF SERVICE: _____

Does applicant/patient have health insurance?: () Yes () No

Is applicant/patient employed?: () Yes () No

If not employed, what was the date of last employment _____

Does applicant/patient collect unemployment?: () Yes () No

If no, has applicant filed for unemployment: () Yes () No

Is applicant age 65 or over?: () Yes () No

Is applicant 19 years of age or younger? () Yes () No

Is applicant legally blind or disabled?: () Yes () No

LIST EVERYONE IN THE HOUSEHOLD THAT YOU ARE FINANCIALLY RESPONSIBLE FOR INCLUDING SPOUSE AND YOURSELF

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FINANCIAL SUMMARY

INCOME

(after taxes and deductions)

Salary \$ _____

Are you paid weekly or every two weeks? (circle one)

Retirement \$ _____

SS/Disability \$ _____

Child Support \$ _____

or Alimony Received.

Food Stamps \$ _____

Unemployment \$ _____

Spouse Income \$ _____

Other Income \$ _____

ASSETS

Cash \$ _____

Savings/checking \$ _____

Stocks/Bonds \$ _____

Briefly explain why you feel that you are financially unable to pay your outstanding account balance at Beaufort Memorial Hospital.

** Proof of income (tax returns, pay stubs, etc.) may be required prior to application being approved.

By signing below I certify the information provided is true and accurate to the best of my knowledge. False, inaccurate or incomplete information may result in this application being denied.

Guarantor Signature

Date

MONTHLY EXPENSES

House/Rent \$ _____

Electric \$ _____

Water \$ _____

Phone/Cell \$ _____

Auto PYMT \$ _____

Food \$ _____

Loans \$ _____

Child Support (paid) \$ _____

House \$ _____

Automobile \$ _____

Medical \$ _____

Life Insurance: \$ _____

Other: \$ _____

*****OFFICE USE ONLY*****

/*/*/*/*/*DO NOT COMPLETE THIS SECTION. OFFICE USE ONLY/*/*/*/*/*

Name of Patient: _____

ACCOUNT #:

Patients net income: _____

100% poverty level: _____

Percent Level: _____

Balance Owed: _____

Due From Patient: _____

Adjustment approval: _____

Comments:

Approval Signature: _____ Date: _____