MNEMONIC: FAA ACTIVE: Y NAME: FINANCIAL ASSISTANCE APPLICATI
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BEAUFORT MEMORIAL HOSPITAL
P.O. BOX 1085
BEAUFORT, SC 29901

FINANCIAL ASSISTANCE APPLICATION

[DATE]

[GUARANTOR NAME]
[GUAR ADR1]
[GUAR ADR2]
[GUARANTOR CITY,STATE ZIP]

Name of Patient: [PATIENT NAME]
ACCOUNT #: [ACCOUNT #]
GUARANTOR SS #: [GUARANTOR SS #]

DATE OF SERVICE: [ADM/SER DATE]

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

The following information is required for this application to be reviewed for
assistance consideration: and should be returned within (10) working days.

1. Denial from Medicaid/MIAP (Should be completed by a DSS worker)

2. Most recent year's Federal Tax Return OR LAST 4 Paystubs.

3. Financial Summary.(Third page)

4. Proof of unemployment with amount, child support/alimony with amount
   disability with amount, retirement with amount.

List Everyone In The Household (Including Yourself)

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NAME DATE OF BIRTH SOCIAL SECURITY NUMBER

_____________________ _______________ _______________________

_____________________ _______________ _______________________

_____________________ _______________ _______________________

_____________________ _______________ _______________________

FINANCIAL SUMMARY

MONTHLY INCOME
(after taxes and deductions)

Salary $__________

Are you paid WEEKLY or BIWEEKLY? (circle one)

Retirement $__________

SS/Disability$__________

Child Support$__________
or Alimony

Food Stamps $__________

Unemployment $__________

Other Income $__________

MONTHLY EXSPENSES

House/Rent $_________

Electric $_________

Water $_________

Phone/Cell $_________

Auto PYMT $_________

Food $_________

Loans $_________

Other Bills $________

Insurance:

House $_________

Automobile $_________

Medical $_________

Life $_________

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Assets:

Cash $__________

Savings/checking acct $__________

Stocks/Bonds $__________

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

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____

____

The information provided is true and accurate. False, inaccurate or incomplete information will result in this application being denied.

_________________________________   ______________
Guarantor Signature   Date

OFFICE USE ONLY
[DATE]

Name of Patient: [PATIENT NAME]

ACCOUNT #: [ACCOUNT #]

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Patients net income: _________________________

100% poverty level: _______________________

Percent Level: ______________________________

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Balance Owed: _______________________________

Due From Patient:____________________________

Adjustment approval: ________________________

Comments: ___________________________________

Signature:___________________Date: __________

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I CERTIFY THAT THE INFORMATION I HAVE PROVIDED FOR THIS APPLICATION IS TRUE
AND ACCURATE. FALSE, INACCURATE, OR INCOMPLETE INFORMATION WILL RESULT IN
THIS
APPLICATION BEING DECLINED.