

Beaufort Memorial Hospital

Financial Assistance Application

Patient's Name _____

Date _____

All the following financial documents MUST be returned with this completed and signed application.

Required Documents:

- Proof of citizenship or lawful permanent SC residence status (valid visa/green card)
- Photo Identification (SC driver's license, SC state issue ID Card)
- Most recent pay stubs (3 weeks) or Supplemental Security Income.
- Other monthly income (i.e. rental income, pension, annuities, child support, VA benefits)
- Most recent bank/credit union statements (3 months), checking/savings, IRA's, CD's, vacation or Christmas club.
- Most recent Federal Income tax forms (1040) Including Schedule C if applicable.
- If you do not file taxes provide transcript of Non filing of Federal Income tax.
- If you do not have any income, provide a letter of support from the person(s) providing support. This document must be notarized.
- If you are Self Employed, submit 3 months of your gross business income and business expenses from your business ledger
- You **must** contact our Medicaid eligibility screening partner for financial assistance phone screening: **843-522-5572 or 843-522-5580.**

Please mail COMPLETED application to:

Beaufort Memorial Hospital PFS

955 Ribaut Road

Beaufort, SC 29902

Beaufort Memorial Hospital

Patient Name: _____
(Last) (First) (Middle) (SSN) (DOB)

Guarantor Name: _____
(Last) (First) (Middle) (SSN) (DOB)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____

Date of Emergency and Medically Necessary Visit: _____ Account Number _____

Household Information

Marital Status <i>(circle one)</i>	Married	Single	Separated	Total in Household:
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Dependent Name(s) (attach separate sheet for additional dependents)	Dependent Date of Birth

Employment/Income

Patient/Guarantor Employer:	
Gross Monthly Income Amount: \$	
Income Source – Please attach verification or explanation of current situation	
Spouse or Other Income Source and Gross Monthly Amount: \$	
Total Annual Gross Household Income: \$	
SSI, Public Assistance, VA Benefits: \$	
Do you have an active bank account?	Did you file taxes for the prior year?
Current Asset Balance: \$	

Insurance Verification

Do you have health insurance? (Circle)	YES	NO
Name of Insurance Company and Policy Number:		
If recently unemployed; Are you eligible for COBRA benefits?		

I certify that the information provided is true and to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance.

Signature of Patient/Guarantor

Date