Northeast Georgia Health System, Inc.™

Account #: _____ **CHARITY CARE APPLICATION**

Part 1: Applicant's Information Date: _____

Patient Name: _____ Date of Birth: _____ Age:_____

Applicant's Name (if different than above): _____ Relationship to the Patient: _____

Phone Number: (home) _____ (cell) _____

Other numbers where we can leave a message/speak with someone on your behalf:

_____

Address: _____

Street City Zip

Part 2: What is the reason the patient is applying for Charity?

1. I am applying for a scheduled service at NGHS or one my doctor has asked to be scheduled.
   - ☐ Yes — Who referred you for the service (doctor/other): _____
     Type of service: _____
     Date of scheduled service: _____ --or--
     Doctor's requested timeframe: _____
   - ☐ No
2. I am applying because I have existing bills that I cannot pay.
   - ☐ Yes — Please list the account number(s): _____
     _____
   - ☐ No
3. Do you currently receive services from: The Hall County Health Dept ❑ Good News Clinic ❑ Health Access Initiative ❑ Toccoa Clinic ❑ NGMC Barrow LLC ❑

Part 3: Please answer the following questions from the patient's perspective:

4. What is your marital status? ❑ Single ❑ Married ❑ Divorced ❑ Widowed
5. Are you currently employed?
   - ☐ Yes — Name and address of employer (Including Self Employment and Second Jobs):
     _____
     _____
     Type of Business if Self Employed: _____
   - ☐ No
6. If you are not currently employed, have you been employed in the last 90 days?
   - ☐ Yes — Name and address of employer: _____
     _____
     If previously employed: Were you previously covered by health insurance? ☐ Yes ☐ No
     HR Contact/ Phone: _____
   - ☐ No
7. Do you have any insurance, including Medicare or Medicaid that will be paying for services?
   - ☐ Yes — Name of Insurance: _____
     Policy Number: _____
   - ☐ No

******Please complete backside of this application******

Patient's Name: _____ Date of Birth: _____

8. Is anyone else responsible for a portion of your bill (e.g., liability, auto insurance, worker's comp)?
   ☐ Yes Please list Company, Claim Number, Adjuster Name and Phone:
   _____
   _____
   ☐ No
9. Have you applied for Disability?
   ☐ Yes, denied coverage ☐ Yes, it is still pending ☐ No
10. Have you applied for Medicaid recently?
    ☐ Yes, denied coverage ☐ Yes, it is still pending ☐ No
11. Are you pregnant or have you given birth within the last 60 days? ☐ Yes ☐ No
12. Are the service(s) you are applying for related to cancer? ☐ Yes ☐ No
13. Were you in Foster Care at age 18? ☐ Yes ☐ No
14. Are any of the service(s) you are applying for from an inpatient visit? ☐ Yes ☐ No
15. Are any of the service(s) you are applying for related to care for being a crime victim? ☐ Yes ☐ No
16. Do you receive any Food Stamps or other government assistance such as SSI or RSDI?
    ☐ Yes Program: _____ Frequency: _____ Gross Amount: _____
    ☐ No

Part 4: Household Information

1. Are you a US citizen? _____If no are you a lawful permanent resident/refugee? _____ Entry Date:_____
2. In which county do you live? _____
3. How many people live at your home? _____ (Please list names, ages, and relationships)
   _____
   _____
   _____
4. Do you own a home? Are you making Mortgage Payments?
   ☐ Yes Value _____ ☐ Yes Amount Owed_____
   ☐ No ☐ No
5. Please list your banking account balances: Savings _____ Checking _____
   Bank Names _____Retirement Accounts (IRA, 401K, 403b) _____ CD's _____
6. What is your total gross monthly household income (including alimony, child support, trust funds, or any other income received)? _____

Program/ Income	Employer	Frequency	Gross Monthly Income

Patient/ Self:

Name	Date of Birth	Sex	Social Security Number

Members of Patient's Household:

Name	Date of Birth	Sex	Relationship to Patient	Social Security Number	Has Existing Bill

Patient's Name: _____ Date of Birth: _____

By completing this application, you agree:

- To apply on my family's behalf for Medicaid and/or any other type of potential coverage available to me based upon the information provided on this application.
- To communicate with the Department of Family and Children Services/ The Social Security Administration and other state and federal agencies regarding my present or past eligibility for all programs they administer.
- That all of the information provided is accurate and complete and will be verified. Providing false information will result in a denial of financial assistance. Additionally, NGHS reserves the right to reverse financial assistance if information is found to be false.
- To provide all information within 30 days of submitting an application. I understand that NGHS may obtain my credit history and that, of any adult in the household. I hereby certify that the information I have provided is accurate and complete.

_____ _____

Applicant's Signature Date