

# Financial Assistance Application

Patient Name <i>(Last, First, Middle)</i>		Social Security Number
South Carolina Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No		Travel Visa: <input type="checkbox"/> Yes <input type="checkbox"/> No
U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medical Record Number (office use only):

## Patient or Responsible Party (If patient is under age 18)

Name <i>(Last, First, Middle)</i>		Social Security Number	Birth Date <i>(MM, DD, YYYY)</i>
Address		City	State, Zip Code
Phone	Household Size (Patient, Spouse and Dependents)		Marital Status
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> VA <input type="checkbox"/> Disabled			Employer Name
How Long Employed	How Long Unemployed <i>(MM, DD, YYYY)</i>	Salary/Income	Are you claimed on another tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes provide tax returns of those being claimed)</i>
South Carolina Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No		Travel Visa: <input type="checkbox"/> Yes <input type="checkbox"/> No	
U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No			

## Spouse/Life Partner

Name <i>(Last, First, Middle)</i>		Social Security Number	Birth Date <i>(MM, DD, YYYY)</i>
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> VA <input type="checkbox"/> Disabled			Employer Name
How Long Employed	How Long Unemployed <i>(MM, DD, YYYY)</i>	Salary/Income	

## Legal dependents as claimed on tax return (If more than 4 dependents use separate page)

Full Name <i>(Last, First, Middle)</i>	Relationship	Birth Date <i>(MM, DD, YYYY)</i>

## Coverage Information

I have <input type="checkbox"/> Applied for federal or state medical assistance <input type="checkbox"/> Verified my healthcare exchange plan eligibility <input type="checkbox"/> Neither Reason _____
I have a <input type="checkbox"/> Lawsuit <input type="checkbox"/> Settlement <input type="checkbox"/> Personal Injury Claim <input type="checkbox"/> Liability Claim <input type="checkbox"/> Workers' Compensation Claim <input type="checkbox"/> None Attorney Name _____
Insurance is available through: <input type="checkbox"/> My employer <input type="checkbox"/> Spouse's employer <input type="checkbox"/> Cobra <input type="checkbox"/> None Insurance Information _____
Have you or a family member applied for Medicaid within the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Who Applied _____ County Applied In _____ Date Applied _____ Caseworker Name _____

I have applied for Social Security Disability.  Yes  No  
 If applied, Status:  Denied  Appeal  Attorney Level  Pending  Approved  
 If recently awarded, attach current social security award letter or Disability Benefit Award Letter to spouse and any children

**Bank Account(s) (e.g. 401k, 403b, Money Market, CD, Stocks, Bonds, Savings, Other Investments)**

Company Name	Account Type/Value	Company Name	Account Type/Value

**Property**

Type	Detail	Estimated Value	Unpaid Balance
Primary Residence	<input type="checkbox"/> Own <input type="checkbox"/> Rent		
Secondary Residence/Vacation Home			
Land (number of acres)			
Rental Property			
Business/Farm Equipment			
Other/Recreational Vehicle(s)			

**Sources of Income (Provide documentation for any of the following)**

Income Description	Source	Monthly Income Amount
Interest/Dividends		
Pension/Retirement		
Rental/Property		
Investments		
Self-employment (requires Business & Individual Tax Returns)		
Other		

**Attestation**

I understand that this application applies only to services provided by Greenville Health System (GHS) and GHS Partners in Health, Inc. This does not apply to services provided by others who may have assisted with my care. I understand that not all medical services at GHS qualify for financial assistance.

GHS reserves the right to reverse financial assistance approval and pursue alternate reimbursement or collections as a result of newly discovered information, including insurance coverage, payment to the applicant, or pursuit by applicant of a personal injury claim related to the services received or requested. All payments received by GHS after financial assistance is awarded will result in the reversal of the adjusted amounts to resolve the remaining self-pay balance without creating a balance due or a credit balance.

I hereby certify that the information in this application is true and correct to the best of my knowledge. I understand that providing incorrect information may result in this application being denied. Should the information provided on this application be determined at any time to be incorrect, the financial assistance provided to me by GHS may be revoked and I will be responsible for the original account balance. I further understand that if any information I provided should change, I will promptly notify Greenville Health System.

Patient/Responsible Party Signature	Date (MM, DD, YYYY)

Return application to:  
 Financial Assistance  
 255 Enterprise Boulevard, Ste. 250  
 Greenville, S.C. 29615