UNION GENERAL HOSPITAL INC.

Where were your services rendered:
☐Union General Hospital
☐Union General Ambulance
☐Blue Mountain Family Practice
☐Wal-Mart Clinic

PATIENT NAME _____

ACCOUNT (S) #_____

If you think you may be eligible for financial assistance under the Federal Poverty Income Guidelines, please complete this application and return it with the requested documentation listed below.

For consideration, you must provide **all documentation** listed below that applies to your Family Unit (applicant/patient, spouse/significant other or legal dependants).

- **Check stubs** or statements from your employer indicating the last three (3) months **gross** income.
- If self- employed, please provide a copy of your last **quarter's Business Financial Statement** along with the previous year's **Business Tax Return**.
- **Unemployment** statement showing denial or eligibility including the weekly amount you have received during the last three (3) months.
- **Social Security and/or Disability Benefits** current eligibility letter or copy of previous month Social Security or Disability checks. (If you have direct deposit, send a copy of your last bank statement showing verification of this income).
- Previous years signed **income tax return**.
- Proof of any other income sources such as **food stamps**, **child support, alimony, trust funds, or rental property** received during the last three (3) months.
- Last three (3) months detailed **bank statements** (checking and savings accounts)
- Proof of residency. (**Rental agreement**, **utility bill, property tax assessment notice**)
- Copies of any and all **expenses** you have on a monthly basis (**water, electric, phone bill**)
- Any other documents as necessary to process this application

If you have no income or limited income sources, please provide the following information:

- A **personal written statement**, signed and dated, explaining the circumstances of your financial situation for the last three (3) months
- A **notarized letter** from the person(s) providing food, shelter and/or financial support for the last three (3) months

Failure to submit the requested information may result in denial of your application because your financial eligibility could not be determined.

Return the application with requested documents to: **Union General Hospital**
35 Hospital Road
Blairsville, GA 30512
Attn: Financial Counselor
(706) 745-2111

- The Assistance for the Charity Program is effective for the charges incurred from Union General Hospital only. The program does not cover, physician charges such as Pathology, Cardiology, Radiology, Anesthesia, private physicians or medication.
- This program is not affiliated with any Medicaid or Medicare or Commercial Insurance programs.
- **This application is valid for thirty (30) days from your request for Financial Assistance.**