Union General Hospital, Inc.
35 Hospital Road
Blairsville, GA 30512
(706) 745-2111

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**)

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 and shelter 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, ambulance 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.**

Patient Legal Name:_______________ **Date of Birth:**___________ **Social Security#**_______________

Mailing Address:_______________ **City/State:**_______________ **Zip Code:**_______________

Street Address (if different): _______________ **City/State:** _______________**Zip Code:** _______________

Home Phone #: _______________**Cell Phone #:** _______________**Business Phone #:**_______________

Employer: _______________ **Occupation**: _______________ **Gross** monthly income: $_______________

List members of Family Unit: (defined as the applicant, spouse, and all legal dependents as allowed by the Federal Government).

Family Member Names	Birth Date	Sex	Relationship to Patient	Social Security Number	Employer/Hire Date	Gross Monthly Income
						$
						$
						$
						$
						$
						$

Proof of other income sources that you receive monthly:	
Supplemental Security Income (SSI)	$
Social Security Disability (SSDI)	$
Unemployment	$
Food Stamps	$
Welfare (AFDC)	$
Veteran's Benefits (VA) S	$
Pensions/Retirement Benefits	$
Child Support	$
Interest/Dlvldends on Investments	$
Other income:	$

Assets:	
Savings Account(s)	$
Checking Account(s)	$
Stocks/Bonds (market value)	$
Face Value of Certificate of Deposit(s)	$
Recreational Vehicles (boats, motorcycles, atvs, etc.)	$
Cars/Trucks	$
Other assets:	$

Hospital Use Only	
Date of Issued	
Issuing Department/Person	
Date Recv'd	
Recv'd By	
MR#	

Monthly Expenses:	
Mortgage or Rent:	
1. Mortgage/Rent monthly payment	$
2. Property Taxes/Insurance	$
3. Appralsal Value of home	$
Utilities: (water, garbage, electric, gas)	$
Cable/Satelite, phone, cell phone and pagers	$
Food and Toiletries	$
Total Automobile Payments:	
1. Auto payment	$
2. Second automobile payment	$
3. Auto fuel	$
4. Auto insurance	$
5. Auto repair expense	$
Credit Cards	$
Loans:	$
Insurance Premiums	
1. Life	$
2. Medlcal	$
Healthcare expenses:	
1. Medical Bills	$
2. Dental Bills	$
3. Prescriptions	$
Child Care Expenses:	$
Other Expenses:	$

I certify that the Information given on this form is true and complete to the best of my knowledge and that it is for the purpose of evaluating my financial condition and ability to pay any bills or charges for hospital services that I have received from Union General Hospital or any accounts which I have signed as Guarantor. I authorize my employer to release information regarding my income which may be necessary In evaluating my financial needs. I agree to promptly notify Union General Hospital of any changes in financial status affecting my ability to pay. By requesting financial assistance, I understand Union General Hospital may inquire Into my (our) credit history.

Signature: _______________**Date:**_______________

Signature of Spouse:_______________ **Date:**_______________

(If married spouse signature required)