Northeast Georgia Health System

Financial Assistance Application

Date: _____ **Account #:** _____

Patient Information

Patient Name		DOB		Social Security Number
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed				Are you a US citizen? ❑ Yes ❑ No
Address	City	State	County	Zip
Phone Number (home)	Phone Number (cell)		Other Phone Number	
Were you in foster care at age 18? ❑ Yes ❑ No		Are you pregnant or have you given birth within the last 60 days? ❑ Yes ❑ No		

Applicant's Information (if different than patient)

Applicant's Name (if different than above)			Relationship to Patient
Phone Number (home)	Phone Number (cell)	Other Phone Number	
Address	City	State	Zip

Goal of Financial Assistance

If applying to help pay for a scheduled service, who referred you for the service (doctor/other)?	Type of Service Needed
What is the date of service?	If service not scheduled yet, what is the timeframe requested by doctor?

Are the service(s) you are applying for related to:

❑ Cancer Care ❑ Inpatient Visit ❑ Care for being a crime victim ❑ No

Are you applying for assistance because you have existing medical bills that you cannot pay?

❑ Yes, account number(s) _____ ❑ Yes, I do not know the account number(s) ❑ No

Employment History

Are you currently employed? ❑ Yes (complete employer questions below) ❑ No (see question below)

Name of Employer		If Self-employed, type of business:	
Address	City	State	Zip

If you are not currently employed, were you employed in the last 90 days? ❑ Yes ❑ No

If yes, were you previously covered by your employer's health insurance plan? ❑ Yes ❑ No

Name of Previous Employer	Address	HR Contact Name	Phone

Patient Name: _____ **Date of Birth:** _____

Household Information

Members of Patient's Household

Name	DOB	Sex	Relationship to Patient	Social Security Number	Has an existing NGHS bill?

Income and Assistance Information

Bank Name	Type of Account savings, checking, IRA, 401K, 403b, CD	Balance

What is your total gross monthly household income (including employment, child support, alimony, trust funds or any other income received)?

Type of Income	Household Member Name	Employer / Program	Frequency	Gross Monthly Amount

Have you applied for Medicaid recently? ❑ **Yes, approved** ❑ **Yes, still pending** ❑ **Yes, denied coverage** ❑ **No**

Have you applied for Disability recently? ❑ **Yes, approved** ❑ **Yes, still pending** ❑ **Yes, denied coverage** ❑ **No**

Please check box if you receive services from: ❑ **Hall County Health Dept.** ❑ **Good News Clinic** ❑ **Health Access Initiative**

Do you have any insurance including Medicare or Medicaid that will be paying for services? ❑ **Yes** ❑ **No**

Name of Insurance	Policy Number

Do you receive any food stamps or other government assistance such as SSI or RSDI? ❑ **Yes** ❑ **No**

If yes, program:	Frequency:	Gross Amount:

Is anyone else responsible for a portion of you bill (e.g., liability, auto insurance, worker's compensation, etc.)?
❑ **Yes** ❑ **No** ***If yes, please provide details below.***

Company Name	Claim Number	Adjuster Name	Phone

Do you own a home? ❑ **Yes** ❑ **No** **If yes, value:** _____

Are you making mortgage payments? ❑ **Yes** ❑ **No** **If yes, amount owe:**_____

By completing this application, I agree:

- To apply (on my family's behalf) for Medicaid and/or any other type of coverage available, 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. This includes use of online account or web portals such as COMPASS.ga.gov.
- That all of the information provided is accurate and complete. Providing false information (as verified by NGHS) will result in a denial or reversal of 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***

Northeast Georgia Health System is not a provider of patient care services; rather, it is a parent organization of a family of affiliate care providers providing financial assistance services for Northeast Georgia Medical Center (NGMC), The Heart Center at Northeast Georgia Medical Center (THC) and Northeast Georgia Physicians Group.