NORTHSIDE HOSPITAL

October 23, 2012

RE:

Dear ,

Attached is an application for our Financial Assistance, charity and indigent care program. Our financial assistance program is based on gross household income. Please send this completed application along with proof of income and all expenses to the address below.

NORTHSIDE HOSPITAL BUSINESS OFFICE
1100 JOHNSON FERRY ROAD SUITE 780
ATLANTA, GA 30342
ATTENTION: FINANCIAL ASSISTANCE

Thank you for your immediate attention to this matter. If you have any questions, please feel free to contact us at (404) 851-6500 between 9:00 AM and 4:00 PM, Monday through Friday.

Sincerely,

Financial Assistance Representative

Business Office

In order to be considered for Financial Assistance, the enclosed forms must be completed and returned with all supporting documentation within 10 days of receipt. Please allow 60-90 days for processing.

NORTHSIDE HOSPITAL – FINANCIAL ASSISTANCE APPLICATION
***** ACCOUNT BALANCES GREATER THAN $2,500.00 *****

MEDICAL RECORD/ACCOUNT NUMBER: ______________________________

PATIENT/GUARANTOR NAME: ______________________________ S.S. #______________________ D.O.B. ______________

SPOUSE/PARTNER NAME: ______________________________ S.S. #______________________ D.O.B. ______________

ADDRESS: ____

PHONE: ______________________________ ALT PH # ______________________________

FAMILY INCOME DATA:

	List Number of Family Members In House Hold:	Monthly Income Per Family Member:
Single Individual	____________	____________
Husband/Partner	____________	____________
Wife/Partner	____________	____________
Children (under 18)	____________	____________
Other Dependants	____________	____________
Total:	____________	____________

OTHER INCOME:

	List Monthly Income Amount
Alimony/ Child Support	____________
Social Security/ Pension	____________
Public Assist / Food Stamps	____________
Unemployment/Workers Comp.	____________
Other Sources (specify)	____________
Total Income	____________

MONTHLY EXPENSES:

	Payment Amount
Rent or Mortgage (Primary and Secondary)	____________
Utilities Standard Deduction (Electric, Gas, Water)	$359.95
Health Insurance/Life Insurance	____________
Medical Bills (Non Northside Hospital)/Pharmacy Report	____________
Child Care/ Adult Care	____________
Government Tax Payments	____________

The undersigned hereby acknowledges the information in this statement to be true and correct to the best of my (our) knowledge. Please note that all applications for financial assistance are subject to verification of employment, obtaining credit bureau reports, other verification process or resources which may be necessary in order to substantiate your financial status.

______________________________ RESPONSIBLE PARTY'S SIGNATURE

______________________________ SPOUSE'S/PARTNER SIGNATURE

IN ORDER TO BE CONSIDERED YOUR APPLICATION MUST BE RETURNED WITHIN 10 DAYS OF RECEIPT

PLEASE NOTE THAT YOUR APPLICATION WILL NOT BE PROCESSED OR CONSIDERED WITHOUT THE FOLLOWING:

1) PROOF OF INCOME

Please provide one of the following:

1. W-2 withholding form
2. Pay stubs. (30 days of current pay stubs)
3. Income tax returns. (Required if self employed)
4. Most recent 90 days of bank statements: checking and savings accounts. (Required if self employed)
5. Forms approving or denying unemployment compensation, workers comp.
6. Written verification of wage from employer.
7. Written verification from public welfare agencies or any other government agency which can attest to the patient's income status for the past 12 months
8. A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for the Medicaid fiscal year have been exhausted.
9. Proof of child support, alimony, Social Security Benefits, and pension.

IF YOU HAVE NO INCOME OR OTHER MEANS OF SUPPORT, PLEASE PROVIDE LETTER OR DOCUMENT FROM PERSON(S), OR ENTITY PROVIDING YOUR PRIMARY SOURCE OF SUPPORT FOR NECESSARY LIVING EXPENSES.

2) COPIES OF RENT/MORTGAGE, HEALTH INSURANCE, MEDICAL BILLS/PHARMACY REPORT, AND CHILD CARE. PLEASE ATTACH PROOF/COPY OF STATEMENT FOR ALL EXPENSES LISTED ABOVE. YOUR APPLICATION WILL NOT BE CONSIDERED WITHOUT THIS DOCUMENTATION.

DO NOT INCLUDE ANY ITEMS THAT ARE DEDUCTED FROM YOUR PAYCHECK

FOR ANY ADDITIONAL NOTES OR COMMENTS ATTACH A LETTER.