EDGEFIELD COUNTY HEALTHCARE
An Affiliate of Self Regional Healthcare

Financial Assistance Application

1. Patient Information

Patient Name: _____ Medical Record Number: _____ Date of Birth: _____

Date of Application: _____ *If the patient is a minor, please list parent/guardian as applicant

2. APPLICANT (GUARANTOR) INFORMATION

Name: _____

Social Security Number: _____

RELATIONSHIP TO PATIENT

☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

MARITAL STATUS

U.S. Citizen? ☐ YES ☐ NO

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Birth: _____ Number of Dependents: _____ Home Phone Number: _____

Cell Phone Number: _____ Address (NO P.O. Boxes): _____

Name of Employer: _____ Employer Address: _____

If not working, how long have you been unemployed: _____

3. FINANCIAL ASSISTANCE QUESTIONS (all answers pertain to the patient)

1. Is the patient applying for assistance with bills for past services at Edgefield County Healthcare? ☐ Yes ☐ NO

If yes, please indicate the last service date: _____

2. Does the patient have health insurance? ☐ Yes ☐ NO

If yes, please provide the following: _____ _____

Health Insurance name: _____ Subscriber Name: _____

Members/Patients Identification number: _____ Group Number: _____

Group/Employer Name: _____ Effective Date: _____

Health Insurance Telephone Number: _____

3. Is the patient eligible for any Federal medical assistance program? (i.e. V.A., Black Lung, etc...) ☐ Yes ☐ NO

If yes, please provide the following information _____ _____

Name of program: _____ Program Telephone Number: _____

Patient Identification Number: _____

4. Is the patient being treated for injuries covered by Worker's Compensation? ☐ Yes ☐ NO

If yes, please provide the following information: _____ _____

Name of Work Comp Carrier: _____ Adjusters Name: _____

Adjuster Phone Number: _____ Injury Date: _____

Claim/Case Number: _____

5. Is the patient being treated for injures covered by Third Party Liability such as an Auto Insurance Company? ☐ Yes ☐ NO

If yes, please provide the following information: _____ _____

Name of Auto Insurance or Attorney: _____ Injury Date: _____

Name of Auto Insurance or Attorney Phone Number: _____ Claim/Case Number: _____

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6. Is the patient a Victim of Crime? ☐ Yes ☐ NO

If yes, please provide the following information:

Name of Case Worker: _____ Date of injury: _____

Case Worker's Phone Number: _____ Case Number: _____

7a. Is the patient 65 or older (without Medicare)? ☐ Yes ☐ NO

If yes, please give a brief explanation why the patient does not have Medicare:

7b. Is the patient under 18? ☐ Yes ☐ NO

8. Is the patient pregnant? ☐ Yes ☐ NO

9. Does the patient have a diagnosis related to the following (check all that apply)? ☐ Yes ☐ NO

☐ Stroke ☐ Chronic Heart Disease ☐ Dialysis ☐ Cancer

10. Has the patient or guarantor had a recent event that would qualify for COBRA benefits (check all that apply)? ☐ Yes ☐ NO

☐ Employment change resulting in loss of job or reduction in hours

☐ Change in marital status resulting in the loss of benefits

☐ Spouse change insurance coverage due to Medicare coverage

☐ Death of a spouse

4. Family Members

Family Member Name	Relationship to Applicant	Date of Birth	Marital Status

5. Income (most recent consecutive check stubs (8 if paid weekly, 4 if paid bi-weekly or two if paid monthly))

Income Type	Family Member Name:	Family Member Name:	Family Member Name:	Family Member Name:
Employment Income	$	$	$	$
Disability	$	$	$	$
Unemployment	$	$	$	$
Investment Income	$	$	$	$

Workers Compensation	$	$	$	$
Social Security	$	$	$	$
Self Employment	$	$	$	$
Spousal/Child Support	$	$	$	$
Pension/Retirement	$	$	$	$
Veteran's Benefits	$	$	$	$
Other (write below):	$	$	$	$
Other (write below):	$	$	$	$

6. List any assets for family members (Checking/Saving Account, Cash on hand, US Saving Bonds, Stocks, Trust Funds, Certificates of Deposit, Face Value of Life Insurance, IRA/Pension Fund, etc...)

Family Member Name	Type of Asset	Name of Bank	Account Number	Cash/Value
				$
				$
				$
				$
				$
				$
				$
				$

7. List any resources that has been sold, deeded or given as a gift in the past three months

Owner	Resource	Account Number	Cash/Value
			$
			$
			$
			$
			$

8. Monthly Expenses for Family Members. If you need more room use the back of this page.

Expense Type	Family Member Name:	Family Member Name:	Family Member Name:	Family Member Name:
House/Mortgage Payment	$	$	$	$
Automobile Expense	$	$	$	$
Credit Cards	$	$	$	$
Child/Spouse Support or Alimony	$	$	$	$
Food/Groceries	$	$	$	$
Liens/Wage Garnishments	$	$	$	$
Other (write below):	$	$	$	$
Other (write below):	$	$	$	$

9. Comments (write any additional comments below that you wish us to review)

10. SIGNATURE

I certify that all information is valid and complete and hereby authorize Edgefield County Healthcare to request a credit check report and/or verify any of the above information as deemed necessary.

APPLICANT SIGNATURE _____ DATE _____

Return completed application to:

Patient Financial Services
300 Ridge Medical Plaza
Edgefield, SC 29824

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