FINANCIAL ASSISTANCE APPLICATION

PLEASE PRINT PLEASE COMPLETE ALL SECTIONS

APPLICATION INFORMATION DATE: DATE OF SERVICE PAST:	MR#:	SOCIAL SECURITY #:

NAME (LAST, FIRST, MIDDLE):

ADDRESS:
(NUMBER) (STREET) (APT. #)

CITY:	COUNTY:	STATE:	ZIP:

HOME TELEPHONE #: ( ) WORK TELEPHONE #: ( )

SEX:	DATE OF BIRTH: / /	PLACE OF BIRTH:

(CITY/STATE) (IF LOCAL, NAME OF HOSPITAL)

RACE: _____ RELIGION: _____ PRIMARY LANGUAGE: _____

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

HAVE YOU BEEN TREATED PREVIOUSLY AT GRADY? ☐ YES ☐ NO

IF NO, MOTHER'S MAIDEN NAME: _____

EMPLOYER: _____
COMPANY NAME ADDRESS PHONE #

INSURANCE COMPANY: _____
(NAME, GROUP #, POLICY #)

OTHER INSURANCE COVERAGE: _____

SPOUSE'S HOSPITAL / MEDICAL INSURANCE: ☐ YES ☐ NO

INSURANCE COMPANY: _____

MEDICARE #: _____ **MEDICAID #:** _____

 # OF DEPENDENTS (UNDER 18) _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

ADDRESS: _____ **TELEPHONE: ( )** _____
(NUMBER) (STREET) (APT. #)

CITY: _____ **STATE:** _____ **ZIP:** _____

****** FINANCIAL INFORMATION ******

GROSS (SELF) INCOME $_____ **CIRCLE ONE:** WEEKLY BI WEEKLY MONTHLY

GROSS (SPOUSE) INCOME $_____ **CIRCLE ONE:** WEEKLY BI WEEKLY MONTHLY

_____

FOR INTERNAL USE ONLY: ANNUAL INCOME: _____

AFFIDAVIT: **I hereby swear that the information I have given related to my legal residence and financial condition, as recorded in my presence, is absolutely true and that it may be verified by an authorized representative of the Grady Health System. I hereby consent to the release of my financial assistance application, financial information and record to external auditing firms for appropriate review/audit. I further agree that as a condition of any present and future treatment at the Grady Health System, I will take all actions necessary to pursue and obtain any third party coverage for which I may be eligible (such as, Medicare, Medicaid, Cancer State Aid, Crime Victims, etc.) to pay for hospital services and supplies provided to me.**

I understand and acknowledge that a representative of Grady Health System may verify, at any time, any information provided by me to Grady. This may include obtaining a credit report, verifying employment, salary, assets and other information that I may provide. I also agree to report any changes in my income and/or insurance status during my financial assistance period to a representative in the Financial Counseling Department.

_____

SIGNATURE OF PATIENT / PATIENT REPRESENTATIVE

_____

SIGNATURE OF FINANCIAL COUNSELOR