Edgefield County Hospital

Receipt of Medical Financial Assistance Application

I acknowledge that I received a Medical Financial Assistance Application for the following Patient Account(s):

Patient Name	Account #	Date of Service	Current Balance

I understand that I must return application and requested documentation by _________________.

I understand that if I do not return application by requested date, any amounts that are the patient's responsibility will be subject to standard collection efforts.

Please provide the best phone number that will allow us to contact you with questions in order to process your application:_________________

***Name of Patient**___________________________

***Signature of Guarantor**________________________

Date application given or mailed to Guarantor____________________

Application distributed by____________________
(Employee of Edgefield County Hospital)

Please provide this information by ________________.
If not returned by this date, your application will be denied and you will need to reapply based on your circumstances at the time of application.

Failure to return this MFA application with needed documents will subject all accounts to normal collection procedures.

Please return the application in the self addressed, stamped envelope, Attention: Medical Financial Assistance Representative.

If you would like an appointment, please contact the MFA Representative at 803-637-9883.

____
MFA Representative
Edgefield County Hospital
PO Box 590
Edgefield, SC 29824

You may fax application and documents to: 803-637-9886

Edgefield County Hospital
Medical Financial Assistance

Applicant's Name: ______________________________ **Date:** ____________

Patient's Name: ______________________________ **Date:** ____________

You have applied for financial assistance relating to your hospital bill. Signing the application states your intent is to receive financial assistance by providing sufficient information necessary to make an accurate determination.

Please, provide the following documents that will be needed for processing the application: (Only send or bring in documents that apply to applicant or patient(s).)

- ☐ Social Security Card
- ☐ Picture I.D.
- ☐ Verification of household members
- ☐ Proof of gross income received by ____________________
- ☐ Most recent Federal Tax Return
- ☐ All bank or other statements for the most recent month
- ☐ Tax receipts or notices on all real and personal property (Vehicles, boats, campers, motorcycles)
- ☐ Proof of amount owed on real and personal property
- ☐ All medical/life insurance policies or cards
- ☐ Proof of Application for Food Stamps *
- ☐ Proof of Application for Unemployment*
- ☐ Proof of Application for Medicaid *
- ☐ Other

If you have any questions, Please call 803-637-9883. Thank you -

*This documentation can be obtained from The Department of Social Services, The Unemployment Office or The Department of Health and Human Service.

I. APPLICANT -IDENTIFYING INFORMATION

Applicant Name: Home Phone Work

DOB: SSN: Race Sex Marital Status

Mailing Address: County of Residence:

Physical Address County of Residence:

How long at this address? If less than 6 months, give previous address, including county:

Is applicant a minor who does not live in the home of his/her parent(s)? yes (under 19 years) no

If yes, give parent(s) name, address, and county of residence:

Address:

Is the applicant a citizen or permanent resident alien? yes no

II. THIRD PARTY INFORMATION ON APPLICANT

Do you have any health insurance? yes no

If yes, give name of company and number for each policy, including Medicare and Medicaid.

Company: Policy Number:

Company: Policy Number:

Is this illness due to an accident? yes What kind?____________________ no

Have you applied for Medicaid? yes On what date?____________ no

Have you applied for hospital services through another government program? yes no

If yes, check all that apply. Veterans Administration Commission for the Blind Food Stamps

Other(specify) : Date applied for:

Comments:

III. MEMBERS OF THE APPLICANT'S FAMILY WITHIN THE HOUSEHOLD

Name	Relationship to applicant	Date of Birth	Marital Status

IV. INCOME

Do you or other family members have income? yes no (Income includes wages or salary before deductions, net receipts from self employment, regular assistance payments such as AFDC or SSI, Social Security, Veterans benefits, pension or other retirement income, unemployment compensation, workman's compensation, child support or alimony, interest income, etc.)

Name	Employment Status	Gross Income	Frequency	Employer Name	Employer Phone Number

If not working now, when was you last day of employment? ______________

Last Employer Name:____________________Do you receive unemployment benefits? yes no
How Much?__________________________ What date did the benefits start? ____________
Have you or anyone in your family received a lump sum payment in the past 13 weeks (income tax refund, insurance settlement, etc.)? yes no
If yes, amount received $__________ From who?____________________________

Comments:

V. RESOURCES

Do you or other family members own real property (Home, Land, Second Home, Mobile Home, Life Estates, Etc)?

No **If no,** *provide the following information: If you live with someone and you do not pay rent, please provide a letter from the person you are living with.*

If you rent, *please provide rental agreement or letter from property owner or manager.*

Yes **If yes,** *give the following information:*

Type	Owner	Street	City	Appraisal Amount	Amount Owed	Equity
					Total Equity:	

Do you or other family members own taxable property (cars, trucks, boats, vans, mobile homes, motorcycles, or other kind of vehicles)? yes no If yes, please give the following information:

Type	Owner	Year, Make, Model	Appraisal Amount	Amount Owed (if any)	Equity
				Total Equity:	

Do you or other family members own liquid assets (cash on hand, checking accounts, saving account, US Savings Bonds, Stocks, Trust Funds, Certificates of Deposit , Face value of Life Insurance, IRA/Pension Fund, etc)? yes no If yes, give the following information :

Type	Owner	Name of Bank	Account Number	Cash/Value
			Total Cash/Value	

VI. TRANSFER OF RESOURCES

Have you or other family members sold, deeded or given as a gift any resources in the past 3 months?

yes no If yes, give the following information:

Type	Owner	Location	Account Number	Cash/Value
			Total Cash/Value	

Debts	Actual Monthly Payments/Expense
Credit Card Monthly Payments	
Utilities (Power,Gas,Phone,Cable)	
Groceries	
Prescription & Non Prescription Drugs	
Dependent or Nursing Home Care	
Tuition	
Health Insurance	
Auto Insurance Premiums	
Other	

VII. STATEMENT OF UNDERSTANDING

I understand that my case record is confidential and no information will be released unless properly authorized by me or as provided for under the Medically Indigent Assistance Act.

I certify that I have read or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding any situation, I am liable for prosecution of fraud and denial of application.

By my signature, I authorize the release of any information needed to determine my eligibility for the Medical Financial Assistance Program.

Applicants Signature:		Date:
Signature of Responsible Person or Authorized Representative: Address	Relationship:	Date:
Witness (signature by a mark "X" requires two witnesses	Hospital Representative	Date: