Washington County Regional Medical Center and Extended Care Facility

610 Sparta Road, or Post Office Box 636 Sandersville, Ga. 31082

Office of Financial Counselor 478-240-2168

The items checked below must be received from _____ by _____. Without these items we will not be able to determine your eligibility for financial assisitance.

Pay check Verification for each member of your household that is employed.

If paid **weekly**, must provide last **4** check stubs from date of this form.

If paid **biweekly** or **semi monthly** must provide the last **2** check stubs from date of this form.

If paid **monthly**, provide the last **full month** check stub from date of this form.

Self employed individuals must complete the self employment form.

UNEARNED INCOME FROM STUDENT PELL GRANTS, SCHOLARSHIPS- CURRENT ENROLLMENT STATUS

Social Security Retirement, Disability or Supplemental Income

You can obtain a status letter by visiting WWW.SSA.GA.GOV (you will need to create login and password information if you have never used this site) Or provide your social security benefit letter.

Unemployment benefits-

A letter from the Dept. of Labor indicating your weekly wages or the last 4 check stubs you have received. If you recently stopped getting Unemployment you will need to verify this information by letter from DOL.

Child Support

If you receive Child support through Child Support Enforcement, you will need to verify this with a status letter or court ordered documents. If you receive direct child support – A signed and dated letter from the father of child indicating amount. (Or items provided)

Worker's compensation, Disability from an employer/past employer or Employee Retirement

Provide a letter dated within the last 30 days from the company indicating the amount you receive monthly.

Income from Family or Friends

Please provide a detailed letter from individual(s) providing you with money or personal items.

The following items are also needed to determine your eligibility dated within the last 30 days:

Electric and Phone Bill Car tag receipts Proof of Rent/Mortgage

20___ copy of income taxes filed. Food stamp benefit letter (www.compass.ga.gov)

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Financial Assistance Application / Worksheet

Patient Name _____ Guarantor Name_____

Date of Service_____ Account Numbers _____

Complete the chart below for **ALL** household members in which applicant/guarantor resides.

Name	Birthdate	Relationship	Income Amount /How often received?

Please list the amount you pay for each household service. Indicate the amount of food stamps received in the household.

Housing	
Electric Bill	
Water & Sewage	
Gas for heating	
Cell phone and Land line	
Auto Payment	
Auto Insurance	
Home Insurance	
Property Taxes	
Food Stamp Income	

Individual providing patient/guarantor income	Amount of income provided/ How often?

I have answered all the questions above true and correct to the best of my knowledge. I can provide all verification as requested.

Signature _____Date_____

WASHINGTON COUNTY REGIONAL MEDICAL CENTER

INDIGENT OR CHARITY CARE PROGRAM

OFFICE OF FINANCIAL COUNSELING

PHONE 478-240-2168 FAX 478-240-2016

610 SPARTA ROAD

PO BOX 636

SANDERSVILLE, GA.

31082

As of Sept. 1, 1994, Washington County Regional Medical Center is offering programs for Indigent and Charity Care. Those who may qualify would fall below the 125% Federal Poverty line for Indigent and 150% for Charity Care. In order to apply we must have the total number of individuals residing in your household as well as the household income for the last 12 months. Household income consist of any income that is provided by individuals other than household members to assist with expenses, food stamps, wages, child support, alimony, and self employment income.

Applicants may be required to apply for Medicaid though the Dept. of Family and Children Services and / or the Social Security Administration. Verification of this process will be required and can be obtained from Dept. of Family and Children services by accessing their website at WWW.COMPASS.GA.GOV or the Social Security Administration's website at WWW.SSA.GOV

Patient Name_____ Guarantor Name_____

Address _____

Contact phone number: Home _____Cell _____Work _____

Name/Address of Employer_____

Name	Date of Birth	Social Security Number	Annual Income

Patient Number	DOS	Amount	Patient Number	DOS	Amount

Total Household Income_____

The above patient IS or IS NOT covered for Indigent / Charity.

Financial Assistance Approval expires (Month/year)_____

Fin. Counseling Signature _____Date_____

Approval by Supervisor _____Date_____