

**FLOYD MEDICAL CENTER – POLK MEDICAL CENTER – FLOYD CHEROKEE MEDICAL CENTER  
INCOME BASED HOSPITAL ASSISTANCE PROGRAM APPLICATION**

Eligibility is based on household size, gross household income, asset value and liability. In order to determine eligibility, please complete and return this form to a Financial Counselor within 14 days along with **proof of current income, last year's tax return/1040, and most recent bank statement.**

Patient Name: \_\_\_\_\_ Account number \_\_\_\_\_

**LIST ALL MEMBERS OF THE HOUSEHOLD, DATES OF BIRTH, RELATIONSHIP TO PATIENT AND INCOME FOR EACH PERSON. INDICATE WHETHER INCOME IS WEEKLY (WK), BI-WEEKLY, SEMI-MONTHLY, MONTHLY (MO) OR YEARLY (YR)**

NAME	BIRTHDATE	RELATIONSHIP	GROSS INCOME/WK, MO, YR, etc.	INCOME SOURCE (SSI, Social Security, Unemployment, Wages, Child Support, Alimony, Odd Jobs and self-employment, etc.)
		PATIENT		

If income for any member is from self-employment, you may give information on business costs so that we can determine actual income to be counted. Verification of circumstance may be requested. Income Tax Returns will be required to include children 18 years old or older or other dependent adults.

If you reported zero income, how are your needs being met? \_\_\_\_\_

Have you applied for or plan to apply for any insurance benefits including Medicare or Medicaid? Yes  No

Do you have a claim pending at this time with Medicare, Medicaid or Disability? Yes  No

Did you file income taxes for the past year? Yes  No

When did you last work? \_\_\_\_\_ (Approximate date) Last employer? \_\_\_\_\_

Do you own the home where you currently reside? Yes  No  Estimated Value of property: \$ \_\_\_\_\_

Do you own property, other than your home, or where you currently reside? Yes  No  Value of property: \$ \_\_\_\_\_

Do you own a vehicle? Yes  No  Estimated Value: \$ \_\_\_\_\_

Do you own additional vehicles? Yes  No  If yes, Type of vehicle(s) and Estimated Value(s): \_\_\_\_\_

Total amount owed on all the assets listed above: \$ \_\_\_\_\_

What is the total monthly payment amount you owed on the assets listed above? \$ \_\_\_\_\_

Do you have a cash reserve? Yes  No  Estimated amount \$ \_\_\_\_\_

Do you have a checking account? Yes  No  Balance \_\_\_\_\_

Do you have a savings account? Yes  No  Estimated balance \_\_\_\_\_

Do you have a retirement account of any kind? Yes  No  Estimated balance: \_\_\_\_\_

Do you own stock or bonds? Yes  No  Estimated Value: \_\_\_\_\_

Do you own a Certificate of Deposit? Yes  No  Estimated Value: \_\_\_\_\_

Have you inherited or won any property or money or received any lump sum payments during the last year?

Yes  No  Estimated Current Market Value: \_\_\_\_\_

\_\_\_\_\_  
**PATIENT OR REPRESENTATIVE SIGNATURE**

\_\_\_\_\_  
**DATE**

**Please note:** This transaction affects only Floyd Medical Center/Polk Medical Center /Cherokee Medical Center bills. A determination of eligibility for financial assistance based upon this application for the account listed above is final and is not subject to any subsequent reviews for changes in eligibility. If you received services from physicians not employed by this hospital (this includes the Emergency Room doctor), you may receive bills for treatment they provided.

Financial Counseling office hours are Monday through Friday, 8:00 AM 5:00PM  
Floyd Phone 706-506-6940, Fax 706-509-6941;  
Polk Phone 770-749-4284, Fax 770-749-4128  
Cherokee Phone 256-927-1315, Fax 256-927-1416