Lakeland Community *Hospital* Financial Assistance Application

Attachment A

Patient Name | Patient Account Number | Application Date

Telephone Number | Social Security Number | Birth Date (Month/Day/Year)

Own /Rent Payment: Value:

(street address) (City) (state) (zip)

☐ Employed
☐ Unemployed

Employer (Name, Address and Telephone Number)

Spouse Name | Social Security Number | Birth Date (Month/Day/Year)

Patient's Father (If patient is a minor) | Social Security Number | Birth Date (Month/Day/Year)

Patient's Mother (If patient is a minor) | Social Security Number | Birth Date (Month/Day/Year)

A. Wages: Please provide the wages for each person in your household.

PATIENT WAGES:
$________ Annual Salary
$________ Hourly Rate of Pay
$________ Monthly Salary
#________ Avg Hours Per Wk

OTHER WAGES:
Name
Relationship
Employer
$________ Annual Salary
$________ Hourly Rate of Pay
$________ Monthly Salary
#________ Avg Hours Per Wk

OTHER WAGES:
Name
Relationship
Employer
$________ Annual Salary
$________ Hourly Rate of Pay
$________ Monthly Salary
#________ Avg Hours Per Wk

OTHER WAGES:
Name
Relationship
Employer
$________ Annual Salary
$________ Hourly Rate of Pay
$________ Monthly Salary
#________ Avg Hours Per Wk

B. *Other Resources:* Please provide the total amount of other resources available to you, including all assets, house, savings accounts, checking accounts, CD's, stocks, bonds, trust funds, real estate etc. $____________
Source:________________________

Please provide the amount of yearly income you receive from these other resources, including interest income, dividends, rental income, etc.
$____________

C. *Household Members:* Please provide the number of persons in the patient's household: ________

D. *Income Verification:* Please provide the following documents to verify household income.

- IRS Form W-2
- Paycheck Remittance
- Tax Return
- Bank Statements
- Employer Verification
- Proof of Participation in Governmental Assistance programs such as food stamps, CDIC, Medicaid or AFDC
- Social Security or Unemployment Compensation Determination Letters
- Other, Please Describe

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

I understand Russellville Hospital may verify the financial information contained in this Financial Assistance Application ("Application") in connection with Hospital's evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize Hospital to request reports from credit reporting agencies and the Social Security Administration. I certify that this information is true to the best of my knowledge and I am aware that falsification of information on this Application may result in denial of financial assistance.

____________ Date: ______
Signature of Patient or Responsible Party

____________ Date: ______
Hospital/Representative - Title

Application/Proof of Income DUE DATE TO BUSINESS OFFICE: ____________

Lakeland Community Hospital

Attachment B

Financial Assistance Application

Dear Patient:

As part of its commitment to serve the community, Russellville Hospital elects to provide financial assistance to individuals who satisfy certain income and asset requirements.

To determine if a person may qualify for financial assistance, we need to obtain certain financial information as outlined within this application. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please complete the Financial Assistance Application and return the completed form to the following address:

Russellville Hospital
Business Office
ATN: Fianancial Asst Rep
P.O. Box 1089
Russellville, Al 35653
(256) 332-8623
Monday-Friday 8:00am to 4:30pm

You will continue to receive statements and attempts to collect this debt will continue until such time that the application is approved for charity.

Below please find the instructions for completing the financial application. Should you need assistance in completing the form, feel free to contact us at **(256) 332-8604**

Any consideration or potential approval of charity assistance applies ONLY to services provided by Russellville Hospital and is not related or applied any way to any physician bills whether by your attending physician or any consulting, pathologist, radiologist or any other physician which may be involved in your care.

Section A: Wages

In Section A of the Financial Assistance Application, please indicate the Dollar Amount and average hours worked per week that each listed person receives as compensation.

Section B: Other Resources

In the first blank in Section B of the Financial Assistance Application, please indicate the Dollar Amount and the source you have invested in checking accounts, savings accounts, stocks, trust funds etc. In the second blank please indicate the Dollar Amount of income you receive yearly from such investments. For example, in the first blank one might put that they have $5,000 in a savings account and in the second blank they might put that they earn $250 interest yearly on that account.

Section C: Household Members

Section C of the Financial Assistance Application requests information on the number of persons in the patient's household. This number should include the patient, the patient's spouse and the patient's dependents or any other person living in the household providing any support to the household. If the patient is a minor, please include the patient, the patient's mother and/or father and/or legal guardian and any Resident Dependents of the patient's mother and/or father, and/or Legal Guardian and/or significant other.

Section D: Income Verification

In order to consider your request for financial assistance, verification of the wages reported in Section A of the Financial Assistance Application is required. Please provide a copy of any of the following: IRS Form W-2, Wages and Tax Statement; pay check remittance; tax return; bank statement or other appropriate indicator of income.

If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in Section D of the Financial Assistance Application.

Signature and Date:

Please sign and date the Financial Assistance Application certifying that the information contained in the application is true to the best of your knowledge. Signature also indicates that you agree to allow Russellville Hospital to verify the information contained in the application through credit reporting agencies and from your employer. ***Return completed and signed application to the Business Office within 10 days.***

For assistance in completing this application, please contact us Monday through Friday (256) 332-8623 between the hours of 8:00am and 4:30pm.

Application/Proof of Income DUE DATE TO BUSINESS OFFICE: ____________________