Eliza Coffee Memorial Hospital

Shoals Hospital

Charity/Financial Assistance Application

Date: _____

PATIENT INFORMATION

Name: _____ DOB: _____/_____/____
(Last) (First) (MI) MM/DD/YY)

Social Security #: _____

*Present Address: _____
(Street) (City) (State) (Zip)

Previous Address: _____
(Street) (City) (State) (Zip)

Telephone Number: (_____)_____ (_____)_____ (_____)_____
(Home) (Work) (Cell)

*Physical address is required. If mailing address is different, please include.

RESPONSIBLE PARTY INFORMATION

Name: _____ DOB: _____/_____/____
(Last) (First) (MI) MM/DD/YY)

Present Address: _____
(Street) (City) (State) (Zip)

Previous Address: _____
(Street) (City) (State) (Zip)

Telephone Number: (_____)_____ (_____)_____ (_____)_____
(Home) (Work) (Cell)

Relationship to Patient: _____ Social Security #: _____

List all persons residing in household:

	Name	Age	Disabled?	Annual Income
Head of House	_____	_____	Y/N	_____
Spouse	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Other dependents	_____	_____	Y/N	_____

P.O. Box 10005
Florence, AL 35631
(256) 768-8344

INCOME

Desription	Monthly Income
A. GR OSS SALARY for husband	$_____
NET SALARY for husband	$_____
EMPLOYER NAME	_____
B. GROSS SALARY for wife	$_____
NET SALARY for wife	$_____
EMPLOYER NAME	_____
C. DIVIDEND AND INTEREST	$_____
D. RENTAL INCOME	$_____
E. PENSION INCOME	$_____
F. CHILD SUPPORT INCOME	$_____
G. ALIMONY INCOME	$_____
H. ADDITIONAL INCOME	$_____
I. SOCIAL SECURITY BENEFITS	$_____
J. V.A. BENEFITS	$_____
K. WELFARE	$_____
L. OTHERS-LIST	$_____
	$_____
	$_____
Total Income per Month	$_____

EXPENSES

Description	Monthly Expense
A. RENT/HOUSE PAYMENT	$_____
B. FOOD	$_____
C. UTILITIES	$_____
D PHONE	$_____
D. REPAIRS	$_____
E. INSTALLMENT LOAN	$_____
INSTALLMENT LOAN	$_____
F. CAR PAYMENT	$_____
G. VISA/MASTERCARD	$_____
H. OTHER CREDIT CARDS	$_____
I. CELL PHONE/PAGER	$_____
J. CABLE/SATELLITE	$_____
K. CHILD SUPPORT	$_____
L. ALIMONY	$_____
M. MEDICAL TRANSPORT	$_____
N. EDUCATION (Students only)	$_____
O. MONTHLY MEDICATIONS	$_____
Total Expenses per Month	$_____

ASSETS

A. CHECKING ACCOUNT	$_____	F. CAR	$_____
BANK NAME	$_____	G. OTHER ASSETS-List	$_____
B. SAVINGS ACCOUNT	$_____	_____	$_____
BANK NAME	$_____	_____	$_____
C. IRA	$_____	_____	$_____
D. INSURANCE POLICY	$_____	_____	$_____
E. HOME	$_____	_____	$_____
Total Assets	$_____		

I understand that the information I submit is subject to verification by ECM/Shoals Hospital and subject to review by state and/or federal enforcement agencies and others as required. If any information proved to be untrue, the hospital may re-evaluate my financial status and take whatever action becomes appropriate.
I am consenting to charity care administrative services for ECM/Shoals Hospital. I certify under the statutes of perjury that the information on these pages is true and correct and that I do not have the financial means to pay for medical care rendered to the above patient.
If my financial situation changes in the upcoming calendar year, I will report these changes to ECM/Shoals Hospital immediately.

*My signature on this application verifies that if I am entitled to any other medical benefits, including but not limited to, a supplemental insurance policy, that I will provide ECM/Shoals Hospital with this information. Should I choose not to give any information regarding my supplemental insurance carrier, my application for assistance may be denied and I may be held responsible for the total amount of the bills accrued at ECM/Shoals Hospital. I understand that ECM/Shoals Hospital is entitled to access any credit reports necessary to make a determination.

Signature of Responsible Party _____ Date Signed _____

Charity/Financial Assistance Application (Page 3 of 3) Name: _____

Please answer the following questions:
Are you currently on dialysis for kidney disease? Yes _____ No _____

Are you a kidney transplant patient? Yes _____ No _____

Charity Care and discounted care does not cover the following services:

- ✔ Reconstructive surgery
- ✔ Cosmetic surgery
- ✔ Breast implants
- ✔ Breast reduction
- ✔ Teeth extractions, excluding radiation or transplant patients
- ✔ Dentures
- ✔ Treatment for infertility, including but not limited to artificial insemination
- ✔ Addiction Recovery Service
- ✔ Medications
- ✔ Durable medical equipment
- ✔ Services not normally covered by health insurance
- ✔ Services that have been determined non-urgent by physician

This is an example of services not covered under the Charity Care/Financial Assistance program.
This list may not include all exclusions to the program
Should you have any questions regarding your particular plan of care, please feel free to call our office.

We reserve the right to change or update covered or non-covered services without notice.

My signature below verifies that I have read and understand the list and statements above.

Signature _____ Date _____

Approval Signature _____ Date _____

Denial Signature _____ Date _____

If you need help with the application, please call 256-768-8344.