WAYNE MEMORIAL HOSPITAL
865 S. FIRST ST.
JESUP, GA 31545
912-427-6811

Dear Patient/Guarantor,

Attached are application papers for the Indigent/Charity Care financial assistance programs offered by Wayne Memorial Hospital.

Please be aware that ALL sources of payment must be exhausted before financial assistance is considered. Examples of payment would be all medical insurance, third party and liability claims, Dept. of Family & Children Services (Medicaid), and other types of coverage.

If you wish to apply for these programs, please read, complete, sign, and date the application forms.

You must supply the following information:

- Copies of check, check stubs or proof of direct deposit for employment, Social Security, pension, unemployment, workers compensation or any other source(s) of income received in the past 30 days.

- A copy of your most recent complete Federal Tax return. If self-employed; you must include your Schedule C.

- If no income, then you need to have a notarized statement of how your day to day living expenses are met.

Application along with necessary documentation/forms must be returned within 10 days.

Please note: Completing and submitting the application for the Indigent/Charity Care does not automatically relieve you of your financial obligation to Wayne Memorial Hospital. Wayne Memorial Hospital reserves the right to deny any application upon review.

Patient Account Department

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INDIGENT/CHARITY CARE POLICY

Wayne Memorial Hospital will give Indigent/Charity care to those who require services that are considered **Emergent/Urgent,** but are unable to pay. This Indigent/Charity Care fund will be available to all persons without discrimination based upon race, color, national origin, creed or other grounds unrelated to the individuals need for the Emergent/Urgent services of this facility. **However, applicants must be United States Citizens with a Social Security Number and a fulltime resident of Georgia.** A request for financial assistance under this policy must be made by or on behalf of the patient.

Indigent/Charity Care Funds may be given in full or in part based on the applicant's financial situation and/or ability to pay. Criteria for the Indigent/Charity Care will be based on 100% of the Federal Poverty Level Income Guidelines for persons who do not qualify for any state healthcare assistance program(s). Partial discounts will be assessed base on up to 250% of the Federal Poverty Level Income Guidelines. Applicants may qualify based on individual or unusual circumstances. Each applicant will be assessed based on need and financial situation.

Persons requiring Emergent/Urgent care may request a determination on their eligibility for the Indigent/Charity Care prior to the service, after the service is provided or even after a collection action has began. Wayne Memorial Hospital, reserves the right to require proof of financial need. This requirement may be, but not limited to proof of income, listing of assets, denials from public assistance program(s), tax returns or any other information that is necessary to substantiate the applicant's income and ability to pay. In addition Wayne Memorial Hospital requires an application for the Indigent/Charity Care Program to be completed, signed and returned to the Patient Accounts Department.

Wayne Memorial Hospital, reserves the right to verify proof of financial need which may include investigation services provided by an outside agency or credit check through Equifax. Wayne Memorial Hospital reserves the right to automatically deny an application if information provided is found to be false or if requested information necessary to process the application is not provided.

I have read the policy regarding the Indigent/Charity Care Program provided by Wayne Memorial Hospital. I agree to complete the necessary application form and provide the financial information necessary for Wayne Memorial Hospital to make a determination as to my eligibility for this program. I understand that the completed, signed application and necessary information must be returned to the hospital's Patient Accounts Department before a determination of eligibility for the program can be made. I also agree that if I do not qualify for the Indigent/Charity Care Fund or only qualify for a partial discount, that I will cooperate with Wayne Memorial Hospital to establish a reasonable payment plan for any balances I may owe and I will make a good faith effort to honor said payment plan. I also understand that if the information I provide is found to be false, my application for Indigent/Charity Care will be automatically denied without further consideration.

Dated: _____

Applicant or Responsible Party's Name (printed):_____

Applicant's or Responsible Party's Signature: _____

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APPLICATION FOR FREE OR REDUCED CHARGES UNDER THE ICTF/CHARITY PROGRAM

Today's Date: _____/_____/_____
MONTH DAY YEAR

Responsible Party: _____ _____
LAST FIRST M.I. SOCIAL SECURITY #

Patient Name: _____ _____
LAST FIRST M.I. SOCIAL SECURITY #

Patient Address: _____
STREET APT/STE #

_____ _____ _____ _____
CITY STATE ZIP CODE COUNTY

Patient Phone Number: _____ Patients Date of Birth: _____
MONTH DAY YEAR

Date of Hospital Service: _____ Marital Status: Single/Married/Divorced/ Legally Separated/Widowed
MONTH DAY YEAR CIRCLE ONE

Did the patient have health insurance or Medicare/Medicaid at the time of services? Yes_____ No _____
*If you answered "yes," please attach a copy the insurance card (front & back) or Medicare/Medicaid card that covers the patient and complete the following:
Name of Insurance Company: _____

Policy Number: _____ Group Number: _____

Insurance Phone Number: _____ Medicare/Medicaid Number: _____

Please complete the following:

List ALL members of household, birth date, relationship to the patient, and income for each

NAME	BIRTH DATE	RELATIONSHIP	GROSS INCOME	TOTAL
			Per week, month or year	
			Per week, month or year	
			Per week, month or year	
			Per week, month or year	
			Per week, month or year	

(Note to Applicant: You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills, and would not be counted or report income.

However, you must list your **spouse or significant other** along with any minor dependents living in your home. A copy of your most recent tax return must be submitted to show how many dependants are claimed if you listed an adult as one of your dependents.

In addition to the completed financial application, we will also need the following information:

proof of gross income for all household members; including the last 2 most recent paycheck stubs **or** most recent federal tax return, child support, alimony, or Social Security income statements, unemployment compensation letter, notarized statement of income or proof of Food Stamps.

By my signature below, I certify that I have carefully read this application and that everything I have stated or provided in any attachment is true and correct to the best of my knowledge and belief. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Responsible Party Signature: _____ Date Completed: _____

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If you reported $0.00 income on the first page, please have the Support Statement below completed by the person(s) helping you and/or your family. THIS HAS TO BE NOTARIZED.

SUPPORT STATEMENT
(TO BE COMPLETED BY THE PERSON(S) PROVIDING SUPPORT)

I have been identified by the applicant as providing financial support. Below is a list of services that I (we) provide for the applicant.

I hereby certify and verify that all of the above information given is true and correct to the best of my knowledge and belief. I understand that my signature will not make me financially responsible for the patient's medical charges.

Signature: _____ Relationship to Applicant: _____
Printed Name:_____
Address: _____
STREET CITY STATE ZIP CODE

NOTARY SIGNATURE: _____
NOTARY SEAL:

FOR HOSPITAL STAFF USE ONLY

Number counted in household: _____
(Average monthly income for last year or past 3 months, whichever is more favorable)
Verification of income supplied: YES _____ or NO _____

Determination: Eligible for free services: YES _____ or NO _____ Conditional _____ Pending _____
Eligible for discount: _____% Conditional _____ Pending _____
Ineligible: Reason _____

Date Notice Mailed: _____ Staff Signature: _____Date: _____

Reconsideration: _____ Staff Signature: _____Date: _____