CMC
Conway Medical Center

Financial Assistance Application

INSTRUCTIONS

- Complete copy of Federal Tax Return Form 1040 including W-2's. If you are self-employed, a Schedule "C" must be included. Please provide all schedules which are applicable.
- If married, two (2) current paystubs for patient and spouse. If separated from spouse, please provide notarized letter.
- Submit copies of your last two (2) bank statements.
- Proof of Alimony or Child Support.
- Proof of Monthly amount of Food Stamps.
- Proof of Unemployment Income.
- If you are a full time student, proof of financial aid and/or student loans. If your parents claim you as a dependent on their tax return, we will need a copy of your parents' current tax return, paystubs and current bank statements.
- If receiving Social Security, a letter showing monthly amount for each person receiving it.
- If another person is helping with your expenses such as rent or food, we will require detailed documentation.
- You must be screened for Medicaid and provide us with an approval or a denial. This can be done with the on-site hospital eligibility workers at 843-234-6958 or 843-347-8183. You may also contact the Conway DHHS at 1201 Creel Street, Conway, SC. or by phone at 1-888-549-0820.
- If your accounts are the result of a motor vehicle accident, and there is a possible settlement, no financial assistance will be available.
- Please complete, sign and date the application and attach all supporting documentation requested. All information will be verified. An incomplete application will be denied.

PLEASE RETURN TO: CONWAY MEDICAL CENTER
300 Singleton Ridge Rd
Conway, SC29526

Financial Assistance Application

Date: ___________________

Patient Information

Account Number(s)____

Patient Name:__________________________________Date of Birth:_____________SS#: _________________

Spouse or Guarantor Name: ____

Date of Birth: _________________ SS#: ____________________

Address: ____

City:________________________State:_______Zip:______________Years/months at residence: ______________

Home Phone:____________________Cell Phone:____________________Other Phone:____________________

Household Information

Member Name	Age	Relationship	Employer	Annual Gross Income
		SELF		$
				$
				$
				$
				$

Total Family Size: _________ Total Dependents:_________Total Household Income: $________________

Screening Information:

- Do you currently have health insurance? (Y/N)__________If yes, please provide insurance info below:
  - Insurance Name: ___________________________ Policy # ____________________
  - Group Name/Number: _____________________________________
- Have you had health insurance that has been terminated in the past 3 months? (Y/N)__________If yes, complete the following:
  - What type of insurance? (i.e. Medicaid, BCBS, Tricare, etc,) ______________________________ ____
  - Reason for insurance termination? _______________________________________
  - Did you apply for COBRA coverage? (Y/N)____________
  - If so, when? __________________________________
  - Former Employer Name: ____________________________
- Are you active duty or retired military? (Y/N)__________ ❖ If so, are you eligible for VA Benefits? (Y/N)__
- Have you applied for Medicaid or SSI Disability? (Y/N)_______If yes, complete the following:
  - When? ___________ ❖ Where? _________________________
  - Caseworker? _______________________
  - Has your household or income status changed since you last applied? (Y/N)___
- Were you a victim of a crime? (Y/N)__________If yes, complete the following.
  - Have you filed a Police Report? (Y/N)___(Must be filed within 72 hrs of incident)
  - Completed Victim of Crime application? (Y/N)___
- If you have any other special circumstances which you would like us to consider when reviewing your application, please explain below:

____

____

____

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Financial Assessment

Account Number(s)____
Patients Name__________________________________Date:__________

Monthly Expenses

Item	Amount
Rent/Mortgage	$__________
Utilities	$__________
Food	$__________
Cell Phone/Pager	$__________
Cable	$__________
Auto Loan	$__________
Auto Insurance	$__________
Loans	$__________
Child Support	$__________
Credit Cards (Min.Payment)	$__________
Other	$__________
	$__________
	$__________
Total Expenses	**$__________**

Assets

Item	Amount
Checking Account(s)	$__________
Savings Account(s)	$__________
Other Cash Assets	$__________
Credit Cards (Available Credit)	$__________

Monthly Gross Income

Item	Amount
Employment Income	$__________
Spouse Income	$__________
Retirement Income	$__________
Food Stamps	$__________
Government Benefits	$__________
Child Support	$__________
Other	$__________
Total Income	**$__________**

TOTAL MONTHLY INCOME $__________

TOTAL MONTHLY EXPENSES $__________

AMOUNT AVAILABLE $__________

Patient/Guarantor Certification

I,____, CERTIFY the information I have provided is true and accurate to the best of knowledge. I understand that if I do not cooperate with the hospital in supplying ANY additional requested information; my application may be denied for possible financial assistance. I understand that the information which I submit is subject to verification by the HOSPITAL, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I understand that this application pertains to hospital charges and not physician's charges. I understand that if any information I have given proves to be untrue, the HOSPITAL will re-evaluate my financial status and take whatever action becomes appropriate. I am also aware that I am only applying for the accounts specified above, and that my financial status will have to be reevaluated and may require a new application for any/all future treatment I receive at Conway Medical Center, Inc.

______________________________ __________
Patient/Guarantor Signature Date

For Office Use Only

Reviewed by:____________________ Date__________	Approved :______________
Recommendation:	____________________ Date__________
Percentage Approved:_____%	____________________ Date__________
D Indigent	____________________ Date__________
D Denied: Reason______________________________	

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Additional Financial Documentation
(Only complete when applicable)

Account Number(s) ____

Patients Name ________________________________ Date: __________

______**Support Statement:**

My signature will certify that I,________________________, do provide all necessary essentials for living for the patient's behalf, and have done so for a period of________years / months.

______________________________ ________________ ______________
Signature of Patient's Supporter Relation to Patient Date

______**Homeless Affidavit**

I, (PRINT NAME) ________________________________ hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

_______________________ __________
Signature Date

______**No Changes to Financial Status since Previous Application for Assistance**

I, (PRINT NAME)________________________________hereby certify there have been no changes to my (nor my spouse's) financial status since my previous application for financial assistance from Conway Medical Center which was completed on_______. Please select of the following options:

D I am still being supported by another. They do provide all necessary essentials for living for my behalf, and have done so for a period of____________years/months.

D I am still homeless. I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

D There are no changes to my (or my spouse's) income or household size since my previous application.

_______________________ __________
Signature Date