USA Health System

Post Office Box 40010
Mobile, AL 36640

(251) 434-3505

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION:

Patient Name:____ SSN:________________

USA Account Number(s):____

Date of Birth: __________________ Employer: _________________________

Address: __________________________________ City:___________________ State/Zip: _________

Home Phone #: ___________________________ Cell Phone #: ____________________________

Marital Status: ____________________

SPOUSE/GUARANTOR INFORMATION (if different from above)

Name: ____ Relationship: __________________

Address: __________________________________ City:___________________ State/Zip: __________

Date of Birth: __________________ SSN: _________________ Employer: _________________________

Home Phone #: ___________________________ Cell Phone Number: ____________________________

Marital Status: ____________________

SPOUSE/GUARANTOR INFORMATION

Number in Household (use separate sheet if necessary):___________

NAME: ______________________________________ AGE: _______ RELATIONSHIP: ______________

NAME: ______________________________________ AGE: _______ RELATIONSHIP: ______________

NAME: ______________________________________ AGE: _______ RELATIONSHIP: ______________

NAME: ______________________________________ AGE: _______ RELATIONSHIP: ______________

NAME: ____ AGE: ________ RELATIONSHIP: _______________

NAME: ____ AGE: ________ RELATIONSHIP: _______________

NAME: ____ AGE: ________ RELATIONSHIP: _______________

HOUSEHOLD INCOME

	Last 12 Months	Last 3 Months
Gross Household Income:	_____________________________	_____________________________

SOURCE OF ALL HOUSEHOLD INCOME:

Employment: ________________ Unemployment: ________________ Child Support: ____________

SSI/SSD: ______________________ Other: (please specify): _____________________________________

I certify that the above information is true and accurate to the best of my knowledge. Furthermore, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available to pay for my hospital charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can judge my eligibility for financial assistance. USA Hospitals reserves the right to verify all given information with credit bureaus and any other persons or creditors they see fit to verify the information that is given. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature: _______________________________________ Date: __________________

DO NOT WRITE BELOW THIS LINE: FOR OFFICE USE ONLY

****

ELIGIBILITY DETERMINATION

Patient Qualifies: Yes ________ No ___________

The applicant's request for financial assistance has been denied for the following reasons:

____

____

____

____

Date of Determination of Eligibility: __________ Date Applicant Notified: _____________

Signature of Hospital Representative: ______________________________________