For assistance in completing application, contact the Patient Financial Counselor at 334-688-7135

Financial Assistance Application

Medical Center Barbour will grant financial assistance to qualified patients on the self-pay portions of their accounts as long as resources are available to finance such care.

In order to receive financial assistance the application must meet the following eligibility requirements:

1. Care rendered **must not** be for experimental, cosmetic, or elective reasons and must be medically appropriate;

2. The applicant is **not** eligible for federal or state assistance (Medicaid, Chips, VA); or

3. There is no other source of payment for the patient's medical bill; for example, medical insurance coverage; and

4. Bad Debt Accounts are **not** eligible for financial assistance (Charity Care).

5. For patients who have multiple visits yearly, an application will be required every six months to ensure all information is accurate.

ATTACHMENTS:

All applicants must attach the copies of the following. **Incomplete applications will be denied.**

1. Federal or State tax returns for last year and, or
2. Copy of most recent social security related income amount if applicable, or
3. Pay stubs for three (3) month for all family unit members who are employed, and
4. Proof of any other source of income.
5. All bank statements for three (3) months, and
6. Copy of denial letter from Medicaid.
7. Any other information deemed necessary by Medical Center Barbour

820 West Washington Street
Eufaula, AL 36027
Attention: Patient Financial Services

FINANCIAL ASSISTANCE APPLICATION

Today's Date: _____

Please answer all questions completely and to the best of your knowledge in order to prevent delaying this application. Copies of income, countable resource and expenses MUST be attached or application will be rejected as incomplete.
IF ALL AREAS ARE NOT COMPLETED, THE APPLICATION WILL BE REJECTED.

Patient Name: _____Phone #:_____
DOB:_____
SSN:_____

Address (including directions: if PO Box include route number):
_____

_____

Age: _____ Marital Status: _____

Account Number	Amount
	$
	$
	$
	$
	$
	$
	$
Total Financial Assistance Requested	$

Section 1 – Household & Employment Information

List all persons living in household.

Name	Relationship/Age	Insurance Coverage

Was this visit to the hospital in any way related to an on-the-job injury or occupational disease? _____

If yes, please explain_____
_____

Are you presently employed: Patient:_____ Part Time:_____ Full Time:_____
Spouse:_____ Part Time:_____ Full Time:_____

Patient's current employer: _____
Employer Address : _____
Phone: _____Length of employment_____
Spouse's current employer:_____
Employer Address : _____
Phone: _____Length of employment_____

If unemployed, list past employment:

	Patient's	Spouse's
Employer:	_____	_____
Address:	_____	_____
	_____	_____
Phone:	_____	_____
Date last employed:	_____	_____

Section 2 – Monthly Household Income & Expenses

Household Monthly Income Supply Copies of Supporting Documents			
Wages	**$**	Food Stamps	**$**
Alimony/Child Support	$	Unemployment	$
Social Security	$	Rent Income	$
Pensions	$	Other Income	$
Retirement	$		
Total Income		$	

Applicant Signature _____ Date_____

FOR HOSPITAL USE ONLY

FINANCIAL COUNSELOR SUBMITTING APPLICATION:

_____DATE:_____

FINANCIAL COUNSELOR ACCEPTING APPLICATION:

_____DATE:_____

INCOMPLETE: _____

****Does the applicant appear to qualify for CHIPS , Medicaid or any other federal or state assistance? If yes, refer to appropriate agency.
FS Clerk Name: _____Date:_____

Remarks:_____

Application must be approved by Business Office Director or Authorized Personnel

Authorization and Certification

Patient Name:

Family Size

Income (Yearly)

APPROVED: _____ % of approval

DENIED:

Approved
By:_____Date:_____

CFO Signature: _____Date:_____

Charity Start Date: _____
Charity Expiration Date: _____