INDIGENT / CHARITY CARE

APPLICATION

P.O. BOX 1297

HAWKINSVILLE, GEORGIA 31036

478-783-0200

GEORGIA INDIGENT CARE APPLICATION

PATIENT		HOSPITAL USE ONLY		
APPLICANT		ACCT #	DATE OF SERVICE	AMOUNT
ADDRESS				
CITY/STATE/ZIP				
PHONE				

LIST MEMBERS OF HOUSEHOLD, RELATIONSHIP TO PATIENT, AND INCOME

NAME	RELATIONSHIP	INCOME	TOTAL INCOME

IF INCOME FOR ANY MEMBER IS FROM SELF-EMPLOYMENT, YOU MAY GIVE INFORMATION ON BUSINESS COSTS SO THAT WE CAN DETERMINE ACTUAL INCOME TO BE COUNTED. WRITE DETAILS ON SEPRARATE SHEET. 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 A SISTER WHO LIVES WITH YOU AND THEY ARE NOT YOUR LEGAL GUARDIAN THAT PERSON IS NOT RESPONSIBLE FOR PAYING YOUR MEDICAL BILLS AND WOULD NOT HAVE TO BE COUNTED OR HAVE INCOME REPORTED.

_____ _____

Signature of Patient/Guardian Date

INDIGENT CARE APPLICATION CHECKLIST

- ☐ YOU MUST COMPLETE INDIGENT CARE APPLICATION, SIGN AND DATE.
- ☐ YOU MUST FIRST APPLY FOR HEALTHCARE INSURANCE COVERAGE THROUGH HEALTHCARE.GOV AND HAVE PROOF OF EXEMPTION.
- ☐ YOU MUST FIRST APPLY FOR ANY MEDICAID PROGRAMS AND HAVE PROOF OF INELIGIBLITY.
- ☐ IF YOU HAVE A THIRD-PARTY SOURCE OF PAYMENT THAT HAS A HIGH DEDUCTIBLE, OUT OF NETWORK BENEFITS OR HAS A COINSURANCE THAT IS A FINANCIAL HARDSHIP FOR THE PATIENT YOU MUST PROVIDE PROOF SUCH AS AN EXPALNATION OF BENEFITS FROM THE THIRD-PARTY SOURCE .
- ☐ PROOF OF INCOME TO INCLUDE:
  - _____ Food Stamp Financial
  - _____ Tax Return
  - _____ Bank Statement / Consecutive Pay Stubs
  - _____ Social Security, SSI, or Other Agency or Person(s)
  - _____ Hardship no income statement
- ☐ PROOF OF RESIDENCY ATTACHED (DRIVERS LICENSE, COPY OF CURRENT UTILITY BILL, OR TAX RETURN)
- ☐ PHOTO IDENTIFICATION (DRIVER'S LICENSE, STATE OR MILITARY ISSUED ID, OR EMPLOYEE OR STUDENT ID)

WITHOUT THE ABOVE INFORMATION , YOUR APPLICATION WILL NOT BE COMPLETE AND CANNOT BE PROCESSED.

Patient Name_____

County_____ Date of Birth_____ SSN_____

Sex_____ Marital Status_____ US Citizen: _____Yes _____No

Spouse's Name_____ Date Of Birth_____

SSN_____

Dependent Children: (Names and Ages) _____

_____

_____

With whom do children live? What relationship is that person to children? _____

_____

List any other household member and their relationship to children? _____

_____

_____

_____

_____

Income/How Often Paid? Employed _____Yes _____No

1. Employer's name & address_____
2. Your Income $_____ Weekly____ Bi-weekly ____ Monthly___
3. Spouse Income $_____
4. Other Income $_____ Weekly____ Bi-weekly____Monthly___
5. Retirement $_____
6. TANF $_____
7. Food Stamp $_____
8. Housing Asst $_____
9. Utility Asst $_____
10. Child Support $_____ Weekly____ Bi-weekly____Monthly___

Expenses(Monthly)

1. Rent/Mortgages $ _____
2. Car Payment $ _____
3. Electric $ _____
4. Gas $ _____
5. Water $ _____
6. Telephone $ _____
7. Cable TV $ _____
8. Medications $ _____

9. Insurance $ _____

10. Other $ _____

INDIGENT CARE FORM---REPORTING NO INCOME

IF YOU ARE REPORTING YOU HAVE NO INCOME. PLEASE DESCRIBE BELOW HOW YOUR LIVING NEEDS ARE MET.

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Taylor Regional Hospital offers Indigent Care to patients with no medical coverage or to patients with a third-party source of payment but has a high deductible, out of network or has a coinsurance that is a financial hardship for the patient who are residents of the state of Georgia and meet criteria based on family-size and income.

Proof of *ALL* income that is received within the household must be submitted with the Indigent/Charity Care application. If no income is received, the patient will be referred to their local Division of Family and Children Services to apply for state or federal programs that assist low-income families and individuals. If the patient is eligible but refuses to apply for any state or federal assistance program; he/she will not be considered for the Indigent Care program.

Proof of Residency with a photo ID must be submitted with Indigent/Charity Care application. A driver's license or state issued ID with your current address will suffice for both proof of residency and the photo ID.
If Indigent Care applicant is a minor (child), the responsible party for minor must provide the requested documents.

***DECO*:** If the account balance reaches $1,500.00, we will refer the account to DECO, an outside agency that will assist in filing for any medical aid that the patient may qualify for. The patient MUST comply with DECO efforts to assist with medical aid. If the account is denied & returned from DECO because the patient was uncooperative, Indigent Funds will not be applied toward the account and the account will follow normal collection procedures.

Please do not submit an incomplete application or an application without the requested documents as an incomplete application cannot and will not be processed.

Once approved for Indigent Care, coverage is valid for 6 months from date of approval unless a change in family size or an increase/decrease in income is reported; at which time a new application must be submitted.
A letter of approval or denial will be mailed to the patient.

Do you (the Patient) have medical insurance? (if yes, please provide proof within 72 hours) ____YES ____NO

Is this visit the result of a motor vehicle accident? (if yes, please provide proof within 72 hours) ____YES ____NO

Is this visit the result of an accident on or at your place of employment? ____YES ____NO

Is this visit the result of an accident in which an attorney may be obtained or a settlement may arise? ____YES ____NO

INDIGENT CARE DOES NOT COVER

MRI
MAMMOGRAMS
PHYSICAL THERAPY
PAIN MANAGEMENT
ELECTIVE SURGERIES
WOUND CARE
PHYSICIAN VISITS / EMERGENCY ROOM PHYSICIAN

EMERGENCY ROOM VISIT (non-urgent, nurse triage only)

By signing below:

- I certify that this form has been examined by me and that the information given is true and correct to the best of my knowledge. I agree to provide Taylor Regional Hospital (TRH) information needed to verify statements given in this application and hereby give permission for their agents to obtain such information on our behalf.

- I understand that TRH may require additional documentation in order to process my application. I understand that I must apply for any other benefits which might pay these accounts before indigent/charity care can be approved. If patient's account(s) meet requirements, account maybe forwarded to DECO. DECO representative may contact patient in order to check patient for GA Medicaid/Disability eligibility. It is a requirement to cooperate with DECO in order to be considered for Indigent Care Funding.

- I understand that the above write-off is for my benefit only and based solely on the disclosure in my application. No release or write-off is granted in connection with any third-party liability, whether the liability arises by contact or negligence. A hospital lien may have been filed naming me as the injured party. Any money recovered by TRH as results of a hospital lien will result in a reversal of the Indigent/ Charity Care approval may be reversed and Legal Action may be pursued.

- I understand that my application will be denied if it is incomplete or I fail to provide required documentation.

_____ _____

Signature of Patient/Guardian Date and Time

This application is not a guarantee that your account will not follow our collection process. Your accounts will NOT be placed on hold pending Indigent/Charity consideration. You will receive an approval or denial letter upon completion of application review.

If you have any questions your application please contact

Kathleen Faulk
Indigent Care Coordinator
Financial Services Manager
Taylor Regional Hospital
478-783-0421

TAYLOR
Regional Hospital

Presumptive Medicaid Eligibility
Pre-determination Questionnaire

Please answer the following questions:

1. Are you pregnant?	YES	NO
2. Are you under the age of 19?	YES	NO
3. Are you the parent/caretaker of any children under the age of 19?	YES	NO
4. Are you a former foster care child aged out of foster care?	YES	NO

Please note, you must be a U.S. Citizen AND a Georgia resident to qualify*

Patient Signature _____ Date/Time _____

Witness _____ Date/Time _____

PE Questionnaire
Date Revised: 8/9/2016
Form #: 3000