920 Cairo Rd
Thomasville, GA 31792

FINANCIAL ASSISTANCE PROGRAM APPLICATION INSTRUCTION SHEET

Archbold Medical Center (AMC) is committed to providing financial assistance to persons who have healthcare needs and are uninsured or under-insured, ineligible for a government program and otherwise unable to pay for medically necessary care based on their individual financial situation. Emergency care will be provided to all patients regardless of their ability to pay. Financial assistance is not considered to be a substitute for personal responsibility and patients are expected to cooperate with AMC's procedure for obtaining financial assistance and to contribute to the cost of their care based on their ability to pay.

To be considered for financial assistance you **MUST PROVIDE** all of the information requested below that applies to your Family Unit (applicant/patient, spouse, and/or legal dependents). The information you provide will remain confidential and will be used only to determine your eligibility for financial assistance.

- ☐ A **completed and signed Financial Assistance Application.**
- ☐ **Proof of Income:** (Please provide each of the following or an explanation of why not provided).
  - Federal Income Tax return(s) for your household for the most recent calendar year.
  - **Four** (4) most recent pay stubs or a statement from your employer regarding your income.
    - **If self-employed**, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return and your Individual Tax Return.
    - Unemployment statement showing denial or eligibility and amount receiving.
  - Written documentation of **all** forms of income: (i.e. social security, food stamps, child support, public assistance, pensions/retirement, alimony, trust funds, stock dividends, etc.)
    - If you have not had any income for the past three (3) months or there has been a recent change in your financial situation you **must** include a statement or letter explaining your situation.
- ☐ **Any other information that demonstrates financial hardship or need for financial assistance.** (i.e. public assistance award or denial letters, letters of support, bank statements, guardianship documentation, etc.)

If you do not qualify for the Indigent Care Trust Fund Program, you **MAY** qualify for Archbold Medical Center's financial assistance program. If you would like to apply for the AMC program, some additional information will be required:

- ☐ **Bank Statements** for all bank accounts for the last two (2) months.
- ☐ **Proof of Residency** (i.e. copy of Utility Bill, Mortgage Coupon, Rental Agreement, etc.)
- ☐ **Identification:** (i.e. driver's license, government issued photo ID, social security card, birth certificate or passport)

Failure to submit the requested information for either program may result in denial of your application because your financial eligibility could not be determined.

Please note that if financial assistance is granted it will only cover your medical bills from our facility. It will not apply to the bills for other medical providers, hospitals, or physicians unless they specifically agree to accept it. **PLEASE CONTACT THE OTHER MEDICAL PROVIDERS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.**

When applying for financial assistance you are giving consent for us to make necessary inquiries to confirm financial obligations or income. If you have questions, please call our Financial Assistance Case Manager @ 229-228-8840.

Send completed applications and all documentation to:

Account Management Services
Attention: Financial Assistance Program
920 Cairo Road
Thomasville, GA 31792-4255

Completed applications and documentation may also be faxed to (229)584-5906 or emailed to fap@archbold.org

APPLICATION FOR
FREE AND REDUCED-CHARGE SERVICES
UNDER THE ICTF PROGRAM
ARCHBOLD MEDICAL CENTER

Patient Name: _____ Date(s) of Service: _____
Amount of charges: $ _____
Name of applicant: _____ Relationship to patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____

List members of household, birth date, relationship to patient, and income from each source; state whether income is per week, month, or year:

Name	Birth Date	Relationship	Income (wk/mo/yr)	Total Income

If income of 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 the back of this sheet.

(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 have to be counted or report income.)

Signature of Applicant: _____ Date: _____

For Hospital Staff Use:

NUMBER COUNTED IN HOUSEHOLD: _____ TOTAL COUNTABLE INCOME: _____
(Average monthly income for last year or past 3 months, whichever is more favorable.)
Verification of income supplied (if requested)? Yes _____ No _____
Determination: Eligible for free services _____ Conditional? _____ Pending: _____
Eligible for discount: _____% Conditional? _____ Pending: _____
Ineligible: _____ Reason: _____
_____
Date notice mailed: _____ Staff Signature: _____ Date: _____
Reconsideration: _____ Result: _____ Date: _____