Web

MUSC/CMH/UMA
Application for Financial Assistance

PRINT

Medical Record # ______________________ **Marital Status:** ______________________

Patient Name ______________________ **SSN** ______________________

Name of Person Responsible for Patient's Balance ______________________ **SSN** ______________________

Work Phone ____________ **Home Phone** ____________ **Cell Phone** ____________

Address ____________ **City** ____________ **State** ________ **Zip Code** ________

Employer Information of Person Responsible for Patient's Balance ______________________________________
Employer Name/Address/Phone Number

If not working, when was your last date of employment? ______________

If you have Health Insurance, provide the insurance company name & policy number:

Insurance Carrier Name	Policy Number

If your visits were a result of or related to Personal Injury/Accident

Date of Accident	Insurance Adjuster's Name and Telephone Number
Attorney Name & Phone Number	Your Auto Insurance Carrier, Policy and Claim Numbers
At-Fault Person's Name, Insurance Carrier, Policy and Claim Numbers	Insurance Adjuster's Name and Telephone Number

Work Related Accident

Date of Accident	Employer Name
Employer Address	Employer Telephone Number
Nature of Injury	Insurance Carrier Name
Insurance Adjuster's Name	Insurance Adjuster's Telephone Number

Are you a homeowner? Y / N **Approximate Value $** ________ **Approximate Balance On Mortgage $** ________ **Monthly Payment $** ________

Do you own a car(s)? Y / N **Approximate Value $** ________ **Approximate Balance On Loan(s) $** ________ **Monthly Payment(s) $** ________

List all household members/dependents as claimed on your Federal Income Taxes. If a person listed below is not claimed on your taxes, you must provide at least one of the following documents for each person: Birth Certificate, Immunization Record, Social Security Card, Current Medicaid Eligibility Letter, Custody Records or Legal Guardianship Document, School Records OR any reasonable document which shows the parent/guardian-child relationship. If you require more lines than are available on this form, use the Dependent Statement form included in this packet.

Name of Family Member	SSN	Relationship to Applicant	Date of Birth	Income Source (Employer, SSI, etc)	Gross Income (Monthly)
					$
Total Income					$

Bank Name/Checking Account #	Average Balance	Bank Name/Savings Account #	Average Balance

Other Assets and Approximate Value (Stocks, Bonds, CDs, Property, Boat, Business, etc)

Asset	Value
$	$
$	$
$	$

Monthly Expenses:

Food $____________ Credit Cards $__________ Car Payment $_________ Loans $__________ Utilities $____________
(excluding house/cars)

Medications $ ____________ Medical Bills $ ____________ Medical Bills $ ____________ Mortgage/Rent $____________
(MUSC/CMH/UMA) (Other than MUSC/CMH/UMA)

Other $____

I, the undersigned, do hereby certify that I have read or had read to me all of the statements on this application and that the information I have provided is true and accurate to the best of my knowledge and agree to report any changes.

I further authorize the release of any information, including financial information, needed to determine my eligibility for the MUSC/CMH/UMA Financial Assistance Program. I understand and hereby further authorize the Medical University of South Carolina, the Medical University Hospital Authority, Charleston Memorial Hospital, University Medical Associates, their affiliates, their collection agencies or attorneys to verify the information contained in this application, including obtaining and reviewing my credit reports or that of the patient, guarantor and/or responsible party.

I understand that my eligibility for a discount will expire after one (1) year and that I must reapply to continue to receive applicable discounts. I understand that the discount approval does NOT cover any visit fees/deposits and would only apply to any patient balance after insurance. I also understand that any discount may be withdrawn should my financial condition change.

Signature ____ Date ________________________

Admissions

Mail this completed form with required documentation (see attached list) to: University Medical Associates, 1 Poston Road, Suite 350, Charleston, South Carolina 29407 Questions: call (843) 792-6200 or (800) 868-5051

(Web)