

# MUSC/UMA Application for Financial Assistance

Account # \_\_\_\_\_ MRN: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Guarantor Employer: \_\_\_\_\_ If not working, when was your last day of employment? \_\_\_\_\_

Do you have Health Insurance?  Yes  No If yes, provide insurance company name and policy number.  
 Name: \_\_\_\_\_ Policy No. \_\_\_\_\_ Name: \_\_\_\_\_ Policy No. \_\_\_\_\_

Were your visits a result of or related to an accident?  Yes  No If yes, provide the information below.  
 Date of Accident: \_\_\_\_\_ Name of Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_

At fault Person's Insurance Co.: \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_  
 Insurance Adjuster's Name: \_\_\_\_\_ Insurance Adjuster's Phone: \_\_\_\_\_

Your Auto Insurance Co.: \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_  
 Insurance Adjuster's Name: \_\_\_\_\_ Insurance Adjuster's Phone: \_\_\_\_\_

**Household Size:** \_\_\_\_\_ **Income: \$** \_\_\_\_\_

**(Please only include household members and dependents as claimed on taxes: family members should be counted whether or not they contribute income.)**

Name of Family Member	Relationship to Applicant	Date of Birth	Gross Income	Frequency (Week/Month/Year)	Income Source (Employer, SSI, etc.)
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		

**PROOF OF INCOME: (Kindly attach the following items. Failure to do so will delay processing of your application.)**

**Provide the following applicable items for each person listed in household above:**

- \* Last Year's Federal Tax Return and all attachments or proof of non-filing.
- \* One (1) month of most recent pay stubs.
- \* Current Checking and Savings statements
- \* Proof of non wage income: alimony, child support, social security, pensions, unemployment, workers comp, income from friends or relatives.
- \* Proof of any of the following assistance that you may receive: food stamps, welfare and subsidized housing.
- \* Proof of Dependents (Copy of income tax return or birth certificates.)

**\*\* If there is no income in the household, please complete the Provider Statement on reverse side.**

## Provider Assistance Statement

I, \_\_\_\_\_ provide food, lodging, and other basic necessities for \_\_\_\_\_. (Applicant)  
 I do \_\_\_\_\_, I do not \_\_\_\_\_, claim the above named patient as a dependent on my taxes .  
 Provider's Signature \_\_\_\_\_ Print Name/Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_

Are you a homeowner? Yes / No    Approx. Value \$ \_\_\_\_\_    Approx. Balance on Loan \$ \_\_\_\_\_  
 Do you own a car(s)? Yes / No    Approx. Value \$ \_\_\_\_\_    Approx. Balance on Loan \$ \_\_\_\_\_

Bank Name	Checking Acct #	Avg. Checking Acct	Savings Acct#	Avg. Savings Acct
		\$ _____		\$ _____
		\$ _____		\$ _____
		\$ _____		\$ _____

**Other Assets and Approx. Value (Stocks, Bonds, Property, Boat, Business, etc.)**

Asset	Value
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____

	<u>Monthly Payment</u>		<u>Monthly Payment</u>
Rent/Mortgage	\$ _____	Loan (Specify)	\$ _____
Food	\$ _____	Medications	\$ _____
Utilities	\$ _____	Medical Bills	\$ _____
Auto	\$ _____	Other \$ _____	\$ _____

I, the undersigned, do hereby certify that I have read or had read to me all of the statements on this application  
 I understand and hereby authorize the Medical University of South Carolina, the Medical University Hospital  
 I understand that my eligibility for a discount will expire after one (1) year and that I must reapply to continue to  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mail this completed, signed, and **PROOF OF INCOME**, to:  
**University Medical Associates, 1 Poston Road, Suite 350, Charleston, SC 29407**