Charity/Indigent Care Application

Date: _____Social Security Number (SSN): _____ Date of Birth (DOB): _____

Patient Name: _____ Account Number: _____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Do you have any type of health insurance? Yes No Do you have a GA Medicaid Card? Yes No Date Issued: _____

Are you on Medicare? Yes No Are you on Social Security Disability with Medicare or Medicaid? Yes No

Are your children on health insurance, Peach Care or Medicaid? Yes No

Address: _____
(NUMBER) (STREET) (CITY) (STATE) (ZIP)

Home Phone: _____ _____Cell Phone: _____ ____Work Phone: _____ _____

Parent or Guardian if patient is under 21: _____

Patient (or Guardian) Employer: _____ Phone: _____

Employer Address: _____

Are you self-employed? Yes No Type of Work: _____

Spouse's Employer: _____ Phone: _____

Employer Address: _____

Is your spouse self-employed? Yes No Type of Work: _____

Full Name of Spouse and/or Legal Dependents Living in Household under 21, SSN, DOB, and Relationship:

1. _____
(NAME) (SSN) (DOB) (RELATIONSHIP)

2. _____
(NAME) (SSN) (DOB) (RELATIONSHIP)

3. _____
(NAME) (SSN) (DOB) (RELATIONSHIP)

4. _____
(NAME) (SSN) (DOB) (RELATIONSHIP)

5. _____
(NAME) (SSN) (DOB) (RELATIONSHIP)

- 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.
- My spouse and I agree to provide Jefferson Hospital with any 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 Jefferson Hospital may require additional documentation in order to process my application.
- I understand that if I give false information a charity care approval may be reversed, and Legal Action may be pursued. Further, I understand that the hospital may obtain any credit history of mine or my spouse.
- I understand that my application will be denied if it is incomplete or I fail to provide required documentation.

Signature of Patient or Guardian: _____ Date: _____Time: _____

Relationship to Patient: _____

Signature of Spouse (if applicable): _____ Date: _____Time: _____

JEFFERSON HOSPITAL
LOUISVILLE, GEORGIA

The following documentation must be provided to process your Charity/Indigent Care application:

- Proof of household income via four most recent pay stubs of all employed in the household. If self-employed, provide a copy of most recent federal income tax filed. Proof of workers compensation, sick leave, disability compensation, welfare, county food stamp letter or social security retirement (SSI not included in income determination), if applicable. If child living with you is under 21 and employed, proof of income may be in the form of a pay stub or certified letter.

- If you are not married but there are children in common, you must provide entire household income. Any child support or alimony received must also be included.

- If you are still legally married but separated, you must provide legal documentation of separation or spouse's income.

- If you lost your job within the last three months, you are required to provide a separation letter from your past employer. Additionally, you must provide a letter from your local Georgia Department of Labor Career Center specifying whether or not you are receiving unemployment benefits. If you have no income at this time, provide a signed letter from the person who provides room and board for you and your family, if applicable.

- Photo Identification for yourself and spouse (Driver's License, State Issued Identification or a valid Work Identification Card)

- Current or recent proof of residency (Utility Bills or Rent Receipt accepted)

You are required to return all information within the next 15 days. This application is not a guarantee that your account will not follow our collection process. Your accounts will not be placed on hold pending charity consideration.
You will receive an approval or denial letter upon completion of application review.

Sincerely,

Jefferson Hospital Indigent Care Program
Office: 478-625-7000 ext. 239
Fax: 478-625-8830 Attention: Indigent
Mail Correspondence:
Jefferson Hospital ICTF
P O Box 528
Louisville, GA 30434

Georgia Indigent Care Trust Fund

Patient Copays Once Approved:

Please ensure that you have bring your Indigent Card with you anytime services are rendered.

These are due upon services rendered:

1. Clinic Visit----------$35.00
2. Emergency Room Visits----------$75.00
3. Routine Services----------$35.00
4. Labs----------$35.00
5. Other Radiology Procedures----------$100.00
    a. CT----------$250
    b. MRI----------$500

6. Surgery----------$250.00
7. Inpatient/Observation----------$100.00 per day

    Payments can be arranged on remaining balance

- Please keep in mind that it is your responsible to make sure that you reapply before your benefits expire. You must report any changes such as new insurance, changes in income, new address and increase or decrease of household members.

- Jefferson Hospital ICTF does not cover Ambulance Services, Radiology readings, Automobile Accidents, Workman's Comp and services ordered by a Non-Jefferson Hospital Physician.

- Failure to comply to the requirements of this program can and will lead to immediate suspension or termination from the Jefferson Hospital Indigent Care Trust Fund.