COLQUITT REGIONAL MEDICAL CENTER

Financial Counseling
PO Box 40
Moultrie, GA 31776
(229) 891-9429 or (229) 891-9065

Indigent Care Program

Applicant Information

Last Name _____ First Name _____ Middle Name _____
Date of Birth _____ Social Security Number _____
Marital Status: Single Married Divorced Widowed (circle one)
Address _____ City _____ County _____ State ___ Zip _____
Phone Number _____ Other Phone _____ Work Phone _____
Applicant's Employer _____ Employer's Phone _____
Applicant's Employer's Address _____City _____State ___ Zip _____
Gross Annual or Monthly Pay: _____
Have you applied for Medicaid? ___YES ____NO Do you qualify for COBRA? ___YES ____NO
Have you applied for food stamps? _____YES ____NO If yes, monthly amount received: $_____

Applicant's Spouse Information
Last Name _____ First Name _____ Middle Name _____
Date of Birth _____ Social Security Number _____
Address _____ City _____ County _____ State ___ Zip _____
Phone Number _____ Other Phone _____ Work Phone _____
Employer _____ Employer's Phone _____
Employer's Address _____ City _____State ___ Zip _____
Gross Annual or Monthly Pay: _____
Have you applied for Medicaid? ___YES ____NO Do you qualify for COBRA? ___YES ____NO
Have you applied for food stamps? _____YES ____NO If yes, monthly amount received: $_____

Legal Dependents

Full Legal Name	Date of Birth	Age	Relationship to Patient	Employed Yes/No	FT Or PT	Social Security Number	Monthly Income
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Assets and Other Sources of Income

Other Income: $ _____ Other Source of Income: _____

Checking Account: Balance $ _____ Name of Bank: _____

Saving's Account: Balance $ _____ Name of Bank: _____

Monthly Pension $ _____ Social Security $_____

IRA $_____ CDs $_____ 401K $_____

Land Owner: ____Yes ____No If yes, how many acres? _____ Value $_____

Do you own rental property? ____Yes ____No
If yes, what is the monthly income? $_____ What is the property value? $_____

Do you own stocks or bonds? ____Yes ____No If yes, what is the value? $_____

Do you have life insurance? ____Yes ____No If yes, what is the value? $_____

Acknowledgements/Authorizations

I/We certify that the above information is true, complete and accurate to the best of my/our knowledge. I/We authorize Colquitt Regional Medical Center to contact and/or release information to other parties (employer, payers, Social Security, third parties, etc) necessary to verify the accuracy of the information provided and the supporting documents submitted as part of the application/process. I/We authorize Colquitt Regional Medical Center to utilize Web sites/online to validate phone numbers, addresses, and/or other supplied information on the application. I/We further authorize the other parties listed on the application to release such information required to validate the information provided as part of the application process to Colquitt Regional Medical Center. I/We acknowledge and understand that failure to provide accurate and complete information may result in denial of the application and participation in the program. I/We certify that all information, supporting documents, and all notarized documents provided are valid and authentic. I/We certify that any driver's license and/or social security numbers provided are valid and legally issued by the state. I/We understand that Colquitt Regional Medical Center is relying on the information provided to determine if you qualify for participation in this program.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____

Signature of Person Completing Application: _____ Date: _____
Reason Applicant Cannot Complete Application: _____

Please return completed application and all documents to the Financial Counselor's Office located at the Main Entrance of the Hospital. To expedite the process please contact a financial counselor to schedule an appointment. Please expect wait times exceeding one hour without an appointment.

For Hospital Staff Use:

Date Received _____ Received By _____

Date Processed _____ Processed By _____

Proof of income attached ___YES ___NO Number in household _____ Total Income _____

DENIED:
Reason: _____ Date Denied _____ PAS Director Signature: _____

APPROVED:
Discount Eligible per FPG _____ Date Approved _____ PAS Director Signature: _____

COLQUITT REGIONAL MEDICAL CENTER

Indigent Care Program Checklist

Please Supply The Documents Requested Below:

Proof of Patient Identification (provide one of the following)

- ☐ Valid Driver's License or Office of Motor Vehicle ID or Military picture ID
- ☐ Current School Identification card with picture
- ☐ Current Employee identification card with picture
- ☐ Valid Passport or Immigration documentation for legal stay in the US
- ☐ Other (please specify): _____

Proof of GA Residency (provide one of the following)

- ☐ Voter Registration Card or other recent Government item with your address
- ☐ Non-expired Georgia driver's license of parent, child, guardian, or spouse.
- ☐ Utility or phone bill in your name at your address Rent Contract or Lease Agreement
- ☐ Bank statement issued within past 60 days with valid Georgia residence address
- ☐ If receiving food stamps, show evidence of signing up in the county of residence
- ☐ Georgia State property tax bill for current or preceding year
- ☐ Refugee DS-20 address verification residency affidavit
- ☐ Other (please specify): _____

Social Security (SS) Cards

- ☐ For all eligible family unit members that need assistance
- ☐ Other Government documents with SS numbers for eligible family unit members
- ☐ Valid Passport or Immigration documentation to validate legal stay in the US

Proof of Employment/Income (provide all sources of income for all members of the family unit that contribute to the household income including yourself and spouse)

- ☐ SSI award letter for current year or bank statements (checking/savings) from the last 30 days showing direct deposit records for any Social Security/SSI or Unemployment deposits. *If Social Security is the only source of income, then application will only need to be updated annually.*
- ☐ Food stamp document for the family unit.
- ☐ Check Stub(s) for prior 90 days from date of application.
- ☐ Student School Financial Aid award letter(s).
- ☐ Retirement/Pension Income.
- ☐ Verification of income from current employer covering prior 90 days or a termination letter on the employer's letter head.
- ☐ Court orders/check for child Support/Alimony or verification of Workman's Compensation income.
- ☐ Previous year's tax return. *If Federal Tax Forms are supplied, then application will only need to be updated annually.*
- ☐ Other (please specify): _____

Proof of Self Employment income (provide one)

- ☐ Most current year Federal Income Tax Form, Include all 1040 schedules**.**
- ☐ Receipts, check stubs, contracts or sub**-**contract agreements.

Verification sources of no income

- ☐ You will be required to complete a notarized "Statement of Support" form at the time of application. *This will have to be updated monthly unless income source changes.*