AUGUSTA HEALTH and AUGUSTA MEDICAL GROUP
FINANCIAL ASSISTANCE PROGRAM

Consistent with its mission to provide high quality health and wellness services for the community, Augusta Health is committed to providing free or discounted care to individuals who are in need of emergency or medically necessary treatment and have a household income below 400% of the Federal Poverty Level (FPL) Guidelines. Individuals who qualify for financial assistance will not be charged more than the average amounts generally billed to insured patients, for emergency or medically necessary care. For a free copy or for more information about the Augusta Health/Augusta Medical Group financial assistance policy, call us at (540) 332-4600, mail a request to the address at the bottom of this page, or visit: https://www.augustahealth.com/business-office/financial-assistance.

IMPORTANT INSTRUCTIONS ABOUT THE APPLICATION PROCESS:

1. Complete the application for financial assistance in its entirety. If any questions do not apply to you, please draw a line or write N/A (Not Applicable). If a question is left unanswered, the application will be considered incomplete.

2. Submit photocopies of the following documentation along with your application (**Financial applications without backup documentations will not be processed)**:

    a. All paystubs for the last three months; yours and your spouse's

    b. All bank statements for the last three months; yours and your spouse's
    If you and/or your spouse are unemployed, you must provide documentation showing how you support yourself and your family.

    Additional documentation may be required upon review.

To be considered eligible for financial assistance, your household income must meet the following criteria:

FEE REDUCTION SCHEDULE

FAMILY INCOME RELATIVE TO FEDERAL POVERTY GUIDELINES	**REDUCTION OF FEES**
0 – 200% of Federal Guidelines	100%
201 – 400% of Federal Guidelines	60%
Greater than 400% of Federal Guidelines	Not eligible

Dependent upon the household income level, the charges will be reduced or eliminated. You may be responsible for a portion of your bill, even though you have been approved. **Approvals are effective for a period of six months.**

Augusta Health will not pursue extraordinary collections actions against an individual without first using reasonable efforts to determine if such individual is eligible for financial assistance.

Financial Advocates are available at (540) 332-4600, Monday through Friday, from 8:00am until 4:30pm to discuss the application process.

If you think you may be eligible for financial assistance, please complete a financial application form and submit it to the following address:

AUGUSTA HEALTH
ATTENTION: BUSINESS OFFICE (FAF)
P.O. BOX 1000
FISHERSVILLE, VA 22939

Upon processing your application for financial assistance, a determination will be mailed to the address provided on the application.

Application for Financial Assistance

Mail application and documents to:
AUGUSTA HEALTH
ATTN: BUSINESS OFFICE (FAF)
P.O. BOX 1000
FISHERSVILLE, VA 22939
Fax: (540) 332-5185

Complete this form in its entirety and submit it along with all yours and your spouse's paystubs and all bank statements for the last three months. **Please note that incomplete and/or unsigned applications will not be processed.**

APPLICANT'S INFORMATION: (Do not leave any fields blank. If not applicable to you, write N/A)

Applicant's Last Name	**First Name**	**Middle Name**	**Date of Birth**	**SSN**

Street Address	**City**	**State**	**Zip Code**	**Phone Number**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed
If unemployed, date employment ended: _____/_____/_____

Employer's Name	**Employer's Phone Number**	**Does employer offer health insurance?** ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No
If yes, Insurance Name: _____ Policy #: _____

State reason for not having health insurance

APPLICANT'S SOURCE OF INCOME: (Complete all that apply and provide documentation for each applicable item below)

INDICATE ALL SOURCES OF INCOME YOU RECEIVE	HOW OFTEN DO YOU RECEIVE IT?	GROSS AMOUNT
Wages or Self-Employment Income	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Social Security Income (SSI)	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Retirement	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Pension	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Supplemental Nutrition Assistance Program (Food Stamp)	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
☐ Alimony/☐ Child Support	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Unemployment benefit	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Other:	☐ Weekly ☐ Bi-weekly ☐ Monthly	$

SPOUSE'S INFORMATION: (Do not leave any fields blank. If not applicable to your spouse, write N/A)

Spouse's Last Name	**First Name**	**Middle Name**	**Date of Birth**	**SSN**

Spouse's Employer	**Employer's Phone Number**

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed
If unemployed, date employment ended: ____/____/_____

Does employer offer health insurance? ☐ Yes ☐ No

Does applicant's spouse have health insurance? ☐ Yes ☐ No
If yes, Insurance Name: _____ Policy #: _____

State reason for not having health insurance

SPOUSE'S SOURCE OF INCOME: (Complete all that apply and provide documentation for each applicable item below)

INDICATE ALL SOURCES OF INCOME YOU RECEIVE	HOW OFTEN DO YOU RECEIVE IT?	GROSS AMOUNT
Wages or Self-Employment Income	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Social Security Income (SSI)	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Retirement	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Pension	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Supplemental Nutrition Assistance Program (Food Stamp)	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
☐ Alimony/☐ Child Support	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Unemployment benefit	☐ Weekly ☐ Bi-weekly ☐ Monthly	$
Other:	☐ Weekly ☐ Bi-weekly ☐ Monthly	$

BOTH PAGES MUST BE COMPLETED TO BE CONSIDERED

APPLICANT'S & SPOUSE'S BANK ACCOUNT INFORMATION: (List all open bank accounts for the last three months)

BANK NAME	ACCOUNT TYPE	CURRENT
	☐Checking ☐Savings ☐Other:____________________	$
	☐Checking ☐Savings ☐Other:____________________	$
	☐Checking ☐Savings ☐Other:____________________	$
	☐Checking ☐Savings ☐Other:____________________	$

(check this box if applicable to you) ☐ **I hereby cerfity that I and/or my spouse do not have a bank account**

DEPENDENTS' INFORMATION: (All your own children or those under your legal guardianship under 18 and living with you)

CHILD'S LAST NAME	CHILD'S FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY	RELATIONSHIP TO APPLICANT

Please provide legal documentation for all children listed above under your legal guardianship.

Do you own or rent your home? ☐Own ☐Rent Monthly mortgage/rent amount: $________________

Do you own a second home? ☐Yes ☐No If yes, monthly rent income: $________________

Do you own or lease your car? ☐Own ☐Lease Monthly car payment amount: $________________

Your estimated monthly living expenses: ☐$0 - $1,000 ☐$1,000 - $2,000 ☐Above $2,000

Did you file taxes for the prior year? ☐Yes ☐No If no, reason: ______________________________________

Have you recently applied for Medicaid? ☐No ☐Yes: Date: ___/___/_____ Status: ☐Denied ☐Pending

Have you recently applied for disability? ☐No ☐Yes If yes, date of application: ____/____/______

Please check all that apply to you: **I am:** ☐Blind ☐Pregnant ☐Disabled ☐Have End Stage Renal Disease(ESRD)

FEE REDUCTION SCHEDULE

FAMILY INCOME RELATIVE TO THE FEDERAL POVERTY GUIDELINES (FPG)	REDUCTION OF FEES
0 – 200% of the FPG	100%
201 – 400% of the FPG	60%
Greater than 400% of the FPG	Not eligible

CERTIFICATION: I certify that the above information is true and accurate to the best of my knowledge and that I understand that if any information herein provided is found to be false, this application will be automatically denied. By signing below, I authorize Augusta Health to verify the information provided in this application with the listed employer(s) and any other listed agencies. I understand that I may be asked to provide additional information and documentation to complete my financial assistance application. I also undertand that I am fully responsible for any portion of my medical bills not covered through this application.

____ ______/______/________

Applicant's Signature **Date**

____ ______/______/________

Spouse's Signature **Date**

- -

OFFICE USE ONLY: Approved by: ____ Date: _____/_____/______

Revised: 03/01/2019