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 FINANCIAL APPLICATION PROCESS:

1. Complete the application in its entirety. If any questions do not apply to you, please cross them out or write N/A (Not Applicable). Married couples should submit a single application.

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

    a. Proof of **gross** income for the last three months; for you and/or your spouse (all paystubs/income statements, Social Security/Disability Letter, Pension Statement, etc.). If you and/or your spouse are unemployed, you must provide documentation showing how you support yourself and your family.

    b. All bank statements for the last three months; for you and/or your spouse. The bank statement(s) **must** show the account number, bank name, and account holder's name and address.

3. Additional documentation may be required upon review.

    To be considered eligible for financial assistance, your household income must meet the following income criteria based on the Federal Poverty Guideline, as published annually by ASPE (https://aspe.hhs.gov/poverty-guidelines):

FAMILY GROSS 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 may be reduced or eliminated. You may be responsible for a portion of your bill, even after 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
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.

Augusta Health

FINANCIAL ASSISTANCE APPLICATION

Mail application and documents to:
AUGUSTA HEALTH 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 ☐Widowed ☐Separated since:_____	**Emp. Status:** ☐Full-time ☐Part-time ☐Self-employed ☐Retired ☐ Full-time Student ☐Unemployed since: _____

Current 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
Wages or Self-Employment Income	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
Social Security Income	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
Retirement	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
Pension	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
SNAP (Food Stamp)	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
☐Alimony/☐Child Support	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
Unemployment benefit	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
Other:	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-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 Current Employer	**Employer's Phone Number**

Emp. Status: ☐Full-time ☐Part-time ☐Self-employed ☐Retired ☐ Full-time Student ☐Unemployed since:	**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
Wages or Self-Employment Income	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
Social Security Income	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
Retirement	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
Pension	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
SNAP (Food Stamp)	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
☐Alimony/☐Child Support	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
Unemployment benefit	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-Monthly	$
Other:	☐Weekly ☐Bi-weekly ☐Monthly ☐Bi-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 ☐ Money Market ☐Other:_____________	$
	☐Checking ☐Savings ☐ Money Market ☐Other:_____________	$
	☐Checking ☐Savings ☐ Money Market ☐Other:_____________	$
	☐Checking ☐Savings ☐ Money Market ☐Other:_____________	$

(check boxes if applicable to you/your spouse) ☐ **I certify that I do not have a bank account.**

☐ **I certify that my spouse does not have a bank account.**

DEPENDENTS' INFORMATION: (Your children or those in your legal custody under the age of 18)

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

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

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)

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: 1/22/2021