AUGUSTA HEALTH and AUGUSTA MEDICAL GROUP
FINANCIAL ASSISTANCE PROGRAM

You may be qualified for a Financial Assistance Discount based on the table below if your gross annual household income is at or below 400% of the Federal Poverty Guideline, as published annually by ASPE (https://aspe.hhs.gov/poverty-guidelines), and household liquid assets are at or below $15,000. **You may be responsible for a portion of your bill even after you have been approved:**

GROSS ANNUAL HOUSEHOLD INCOME	FINANCIAL ASSISTANCE DISCOUNT
0 – 200% of Federal Poverty Guidelines	100%
201 – 400% of Federal Poverty Guidelines	60%
Greater than 400% of Federal Poverty Guidelines	Not eligible for Financial Assistance Discount

IMPORTANT INSTRUCTIONS:

1. Complete the application fully, leaving no item blank. If items do not apply to you, please cross out or write N/A (Not Applicable). Remember to include signature(s). Married couples should submit one application.

2. Submit **photocopies** of the following documentation along with your application (**Financial applications without 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 bank name, account number, account holder's name and address, contain all pages, and show all transactions.

3. Additional documentation may be required upon review.

A determination will be mailed to the address provided on the application. **Financial Assistance is effective for a period of six months from approval and may be applied up to 240 days retroactively to qualifying accounts according to the Financial Assistance Policy.**

PLAIN LANGUAGE SUMMARY

Consistent with its mission to provide high quality health and wellness services for the community, Augusta Health and Augusta Medical Group are committed to providing free or discounted care to individuals who need emergency or medically necessary treatment and have an estimated gross annual household income at or below 400% of the Federal Poverty Level (FPL) Guidelines and have no more than $15,000 in liquid assets. Individuals who qualify for financial assistance will not be charged more than the average amounts generally billed (AGB) to commercially insured patients for emergency or medically necessary care. Augusta Health will not pursue 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. For a free copy or for more information about the Augusta Health/Augusta Medical Group financial assistance policy or application, call us at (540) 332-4600, visit the Augusta Health Business Office located at 189 Medical Center Circle, Fishersville, VA, mail a request to the address at the bottom of this page, or visit: https://www.augustahealth.com/business-office/financial-assistance.

AUGUSTA HEALTH
BUSINESS OFFICE - FAF
P.O. BOX 1000
FISHERSVILLE, VA 22939

Revised: 12/11/2023

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 the application fully, leaving nothing blank. **Incomplete/unsigned applications will not be processed.** If something does not apply to you, write N/A (Not Applicable).

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

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

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated since: _____/_____/_____

Employment Status: [ ] Full-time [ ] Part-time [ ] Full-time Student [ ] Self-Employed [ ] Retired [ ] 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/Member # _____

APPLICANT'S SOURCE(S) OF INCOME: (Complete for all that apply and attach past 3 months of documentation for each)

INDICATE ALL SOURCES OF INCOME YOU RECEIVE	HOW OFTEN DO YOU RECEIVE YOUR INCOME?	GROSS AMOUNT
CURRENT Employment (paystubs)	[ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Bi-Monthly	$
Self-Employment (attach **full** tax return)	[ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Bi-Monthly	$
Social Security Retirement/Disability	[ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Bi-Monthly	$
Retirement	[ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Bi-Monthly	$
Pension	[ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Bi-Monthly	$
Employer Short or Long Term Disability	[ ]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 Last Name _____ **First Name** _____ **Middle Name** _____ **Date of Birth** _____ **SSN** _____

Employment Status: [ ] Full-time [ ] Part-time [ ] Full-time Student [ ] Self-Employed [ ] Retired [ ] 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/Member # _____

SPOUSE'S SOURCE OF INCOME: (Complete for all that apply and attach past 3 months of documentation for each)

INDICATE ALL SOURCES OF INCOME YOU RECEIVE	HOW OFTEN DO YOU RECEIVE YOUR INCOME?	GROSS AMOUNT
CURRENT Employment (paystubs)	[ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Bi-Monthly	$
Self-Employment (attach **full** tax return)	[ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Bi-Monthly	$
Social Security Retirement/Disability	[ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Bi-Monthly	$
Retirement	[ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Bi-Monthly	$
Pension	[ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Bi-Monthly	$
Employer Short or Long Term Disability	[ ]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 AND RETURNED TO BE CONSIDERED

APPLICANT'S & SPOUSE'S BANK ACCOUNT INFORMATION: (List all open bank accounts and **attach statements for the last 3 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) **[ ] I certify that I do NOT have a bank account.**

[ ] I certify that my spouse does NOT have a bank account.

DEPENDENTS' INFORMATION: Your own children or those in your legal custody who are **under the age of 18**

(Please provide legal documentation for all children listed below who are in your physical custody by court order)

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

Do you own or rent your home? [ ]Own [ ]Rent Monthly mortgage/rent amount: $_______________

[ ] Mortgage paid in full [ ] Lifetime rights [ ] I live with someone else and don't pay

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

Do you receive SNAP/EBT benefits? [ ]Yes [ ]No If yes, monthly benefit amount: $_______________

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 understand 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**

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OFFICE USE ONLY:

Approved by: ____ Date: _______/_______/________

Revised: 12/11/2023