

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 \$25,000. **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 or your spouse are self-employed, provide current year tax return or a summary of the last 3 months of business income and expenses. If you have no household income, you must provide documentation showing how you support yourself and your family.
 - b. All bank statements for the last three months (including any online accounts such as Chime, Ally, Dave, etc.); 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 and sub-accounts.
 - c. Three most recent statements for any money sharing apps used (Venmo, Cash App, PayPal, etc.) for you and/or your spouse. Statements **must** include all transactions and month end balance.
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 \$25,000 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



FINANCIAL ASSISTANCE APPLICATION

Office Use Only: Fitness Center Hospice

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) | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Self-Employment (attach full tax return) | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Social Security Retirement/Disability | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Retirement | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Pension | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Employer Short or Long Term Disability | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| <input type="checkbox"/> Alimony / <input type="checkbox"/> Child Support | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Unemployment benefit | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Other: | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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) | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Self-Employment (attach full tax return) | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Social Security Retirement/Disability | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Retirement | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Pension | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Employer Short or Long Term Disability | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| <input type="checkbox"/> Alimony / <input type="checkbox"/> Child Support | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Unemployment benefit | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly | \$ _____ |
| Other: | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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 |
|-----------|--|---------|
| | <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market <input type="checkbox"/> Other: _____ | \$ |
| | <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market <input type="checkbox"/> Other: _____ | \$ |
| | <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market <input type="checkbox"/> Other: _____ | \$ |
| | <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market <input type="checkbox"/> 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.**APPLICANT'S & SPOUSE'S MONEY SHARING APP INFORMATION:** (Check all used apps and attach statements showing all transactions and month end balance for the last 3 months)

| | APP NAME |
|------------------|--|
| APPLICANT | <input type="checkbox"/> Venmo <input type="checkbox"/> Cash App <input type="checkbox"/> PayPal <input type="checkbox"/> Apple Cash <input type="checkbox"/> Other: _____ |
| SPOUSE | <input type="checkbox"/> Venmo <input type="checkbox"/> Cash App <input type="checkbox"/> PayPal <input type="checkbox"/> Apple Cash <input type="checkbox"/> Other: _____ |

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 your home? Own: Monthly mortgage amount: \$ _____ Mortgage paid in full Lifetime rightsDo you rent your home/apartment? Rent: Monthly rent amount: \$ _____ I live with someone else and don't pay rent I live with someone else and contribute monthly \$ _____Do you own a second home? Yes No If yes, monthly rent income: \$ _____Your estimated monthly living expenses: \$0 - \$1,000 \$1,000 - \$2,000 Above \$2,000Do 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: Approved Denied Pending

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**

OFFICE USE ONLY:

Approved by: _____ Date: ___/___/___