MORGAN MEDICAL CENTER

1740 Lions Club Road · P.O. Box 860 · Madison, GA 30650

P: 706-342-1667 · F: 706-342-2345 · www.morganmedicalcenter.org

Morgan Medical Center participates in the Georgia **Indigent Care Trust Fund**.

We receive special funding to assist qualified patients with their medical bills. Each year we will provide services to patients for free or at a reduced rate. You may qualify for help under Georgia's Indigent Care Trust Fund Program.

To determine initial eligibility and /or continued eligibility for the Indigent Care Trust Fund (ICTF), evidence must be provided. The items listed below must be received, along with your completed application. If you need assistance during this process, please contact Patient Financial Services at (**706) 342-1667 Ext. 226**

Documentation Requirements – One document from each category is required

- A complete and signed Financial Application – 3 pages
- Photo ID Acceptable forms (government IDs only)
  - Valid state-issued driver's license
  - State ID card
  - Passport
  - Military ID
  - School picture ID
  - Visa or Resident Alien card
- Proof of Residency
  - Utility bills such as power, gas, water, telephone bill
  - Lease contract
  - Rent receipt showing current address
  - Food Stamps letter
  - Voter Registration Card
  - Other business documents that verify your place of residency, such as credit card statements, IRS, Medicaid letters, student letters from school, cable bill, cell phone bill, bank statements, check stubs with physical address.
- Proof of Income
  - Employed: 2 months last paycheck stubs (patient and spouse)
  - Unemployed: Depart. of Labor unemployment approval letter, or Wage Inquiry (WG-15)
  - Self Employed: 2 Current Bank Statements
  - Previous year's tax forms for unemployed or self-employed patients/spouse

- **Send completed applications and documentation to:**
  Morgan Medical Center
  Attn: Patient Financial Counselor **OR** **FAX: 706-431-9345**
  1740 Lions Club Road
  Madison, Ga. 30650

Failure to submit all requested documents may result in delay or denial of your application. Please note that if financial assistance is granted it will only cover medical bills from our facility. It will not apply to bills for other medical providers, hospitals, or physicians unless they specifically agree to accept it. **PLEASE CONTACT OTHER MEDICAL PROVIDERS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.**

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Financial Assistance Application

Date: _____

Patient Name: _____ Date of Birth: _____ SS#: _____

Spouse or Guarantor Name: _____

Spouse/Guarantor Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Other Phone: _____

Household Information

Member Name	Age	Relationship	Employer	Annual Income
		SELF		$
				$
				$
				$

Total Family Size: ____ Total Dependents: ____ Total Household Income: _____

Screening Information:

- Are you a US Citizen? (Y/N) _____ If not, are you a legal permanent resident? (Y/N) _____
- Do you currently have health insurance? (Y/N) ___ If yes, please provide insurance info below:
  - Insurance Name: _____
  - Group Name/Number: _____
- Have you applied for Medicaid or Disability? (Y/N) _____ If yes, complete the following:
  - When? _____ Where? _____
  - Caseworker? _____
- Are you currently pregnant or had a miscarriage in the last 90 days? (Y/N) _____
- Were you a victim of a crime? (Y/N) _____ If yes complete the following.
- Have you filed a Police Report? (Y/N) _____ (Must be filed within 72 hours of incident)
- If you have any other special circumstances which you would like us to consider when reviewing your application, please explain below:

_____

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Financial Assessment

Patient's Name _____ Date: _____

Assets		**Monthly Expenses**	
Checking Account	$	Rent Mortgage	$
Savings Account(s)	$	Utilities	$
Other Cash Assets	$	Food	$
Credit Cards (Available credit)	$	Cell Phone	$
Total Assets	$	Cable	$
		Auto Loan	$
Monthly Gross Income		Auto Insurance	$
Employment Income (net)	$	Loans	$
Spouse Income (net)	$	Health Insurance	$
Retirement Income	$	Alimony	$
Unemployment Income	$	Child support	$
Alimony	$	Credit cards (min payment)	$
Child Support	$	Groceries	$
Food Stamps	$	Church/Charity	$
Government Benefits	$	Medical Bills	$
Total Income	$	**Total Expenses**	$

I certify the information I have provided is true and accurate to the best of knowledge. I understand that this application pertains to hospital charges and not physician's charges. I am also aware that I am only applying for accounts that belong to Morgan Medical Center only. I understand that my financial status will be reevaluated biannually and will require a new application for any/all future treatment I receive.

_____

Patient/Guarantor Signature Date

****FOR OFFICE USE ONLY ****

Number in household:		**Total Net Income:**	
Recommendation: ☐ Charity: _____ % ☐ Indigent: (100%) ☐ Denied: Reason _____		Date notice mailed: _____ Approved by: _____ Date: _____	
ACCOUNT #	**DOS**	**ORIGINAL BAL.**	**ADJUSTED BAL.**

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Additional Financial Documentation

(Only complete if applicable)

Patient Name _____ Date**:** _____

_____ **Support Statement**:

My signature will certify that I, _____, do provide all necessary essentials for living for the patient's behalf, and have done so for a period of _____ years/months.

_____ _____ _____

Signature of Patient Supporter Relation to Patient Date

_____ **Homeless Affidavit**

I, (Print name) _____ hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

_____ _____

Signature Date

_____ **No changes to Financial Status since previous Application for Assistance**

I, (Print name) _____ hereby certify there have been no changes to my (nor my spouse's) financial status since my previous application for financial assistance.

- ☐ I am still being supported by another. They do provide all necessary essentials for living for my behalf and have done so for a period of _____ years/months.
- ☐ I am still Homeless. I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.
- ☐ There are no changes to my (or my spouse's) income or household size since my previous application.

_____ _____

Signature Date

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Medicaid Screening Form

Name: _____ Date of Birth _____

Address; _____ Phone #: _____

Do you currently have any form of insurance? YES or NO

Is the patient under the age of 18? YES or NO

If yes, who is the guarantor of the minor? _____

Number of **adults** _____ and **minors** _____ living in household.

Are you a US citizen? YES or NO

If no, are you a legal permanent resident? YES or NO

If so since what date? _____

Are you over 65- YES or NO Are you legally blind - YES or NO Are you disabled? - YES or NO

Have you ever applied for disability? YES or NO If so, when? _____

What is your disability? _____ Still pending? _____

Are you a victim of a crime? YES or NO Has a police report been filed? YES or NO

Are you currently pregnant or have had a miscarriage in the last 90 days? YES or NO

Have you recently applied for Medicaid? YES or NO

If yes, when? _____

What is the reason for your visit to the hospital?

_____

Did you file income tax return this year? YES or NO

Are you currently? Single - Divorced - Married - Separated - Widowed

Family Gross income for the current month $ _____

I understand that this information is considered confidential. The sole purpose of this form is to see if the patient may qualify for financial assistance. Should you meet the criteria for assistance, a representative may be contacting you

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Resources for Assistance

Social Security Benefits (must register)

HTTPS://WWW.SSA.GOV/SITE/SIGNIN/EN/

Georgia Department of Human Services (Division of Family and Children's Services)

Help line – 877-423-4746

https://dfcs.georgia.gov

Apply for Medicaid

Apply for Disability

SNAP (Food Stamps)

https://dfcs.georgia.gov/snap-food-stamps

Utility Assistance

Low Income Home Energy Assistance Program (LIHEAP)

https://www.usa.gov/help-with-bills

United Way – Dial 211

https://www.unitedway.org

The Salvation Army

Athens: 706-543-5350

https://www.salvationarmyathens.org

Covington: 770-786-2107

https://www.salvationarmycovington.org