+rmc the Regional Medical Center

For Office Use Only:
Date Mailed/Distributed: ____________________
Recipient Name: ____________________
Address: ____________________
____
Application Received: ____________________

APPLICATION:
Financial Assistance/Charity Care

The following is a financial statement that should be completed in full, signed and returned. **IF YOU DO NOT INCLUDE THE REQUIRED INFORMATION, YOUR APPLICATION WILL BE DENIED.**

Required information includes:
A recent bank statement, your most recent W-2 form, and payroll stub showing year-to-date total income for you and your spouse (if married) are required.

Please print the name and mailing address of the patient and who is responsible for this bill.

____

____

____

List all dependents, including your spouse:

Name	Age	Relationship

Does South Carolina Medicaid cover your dependents? ____________________

If yes, please list names and birth dates, and provide proof of Medicaid

Name	Date of Birth

MONTHLY INCOME

Do you have an income?____________ Amount $ ______________________

Does your spouse have an income?_________ Amount $ __________________

If yes, you must provide a recent pay stub, receipts if self-employed, proof of public assistance payments, Social Security, unemployment, workmen's compensation, child support, alimony, etc. **Documentation is required.**

Assets*

Cash on hand and/or in banks...................................... $ ___________________
(Checking $_______ Savings $_______Credit Union $_______)

Automobiles, boats, motor homes, etc........................ $ ___________________

____
(make, year and model for the above)

Real estate (Property) .... $ ___________________

Mobile home? If yes, what year: ______________ .... $ ___________________

All other assets not specified above: $ ___________________

____
(description and value)

____
(description and value)

____
(description and value)

TOTAL ASSETS... $ ___________________

<u>NOTE</u>: Married person should include spouse's financial information.

If not working now, when was your last day of employment? ______________

Employer Name: ____

Do you receive employment benefits? _____________________________________

Are you receiving Food Stamps? _______ **If yes, please provide <u>current</u> Food Stamp printout.**

<u>Monthly Expenses</u>

Rent or mortgage payments .... $ ___________________

____
(list location and to whom paid)

____
(list location and to whom paid)

____
(list location and to whom paid)

Total household expenses (list below)......................... $ ___________________
(Electricity/Heat/Air $_______ Phone $_______ Food $_______)

Monthly Expenses *(continued)*

Auto or other transportation expenses........................ $ ___________________

Medicines and Medical Care expenses........................ $ ___________________

____

Finance/Loan companies and Credit Card payments.. $ ___________________

____
(list creditor and amount due)

____
(list creditor and amount due)

____
(list creditor and amount due)

Auto Insurance? _________If yes: $ ___________________

Cable TV $________ Movies $_________ Other $ _______

Other: ________________________ $__________________

Other: ________________________ $__________________

Other: ________________________ $__________________

TOTAL MONTHLY EXPENSES..................................... $ ___________________

How do you pay these bills? ____________________________________

____

____

I hereby swear or affirm under the penalties of perjury that the information provided is a complete and accurate statement of my financial condition.

__________________ ____
Date Patient / Guarantor Signature