Jasper Memorial Hospital Financial Assistance Program – Plain Language Summary

Summary – Jasper Memorial Hospital (JMH) helps eligible people take care of their bills with the Hospital. We use the same income and family size guidelines that the Federal Government uses for many of their programs. Based on your family size and income, you may get discounts or even free care, but you do have to turn in an application and give us some information to confirm your family income.

Where to apply – You can download an application from our website, jaspermemorialhospital.org , by going to the About Us link, and selecting Bills and Insurance. At the bottom of the page is a link to a printable copy of the application. You can also get a copy of the application from anyone in our Registration area, or you can call the Hospital at 706-468-6411 and ask us to mail you a copy. If you need the information in a differently language, let us know and we will have it translated for you.

A patient eligible for financial assistance may not be charged more than amounts generally billed for emergency or other medically necessary care. Jasper Memorial Hospital charges the same amount to our patients and provides discounts to those in need who give us enough information on family income and family size to prove they qualify for our assistance program.

JASPER MEMORIAL HOSPITAL

PATIENT FINANCIAL ASSISTANCE PROGRAM (PFAP)
FREE AND REDUCED-CHARGE SERVICES APPLICATION

Name of Patient: _____ Date of Birth: _____

Name of Applicant: _____

Address: _____City _____, GA Zip_____

Telephone: _____ County: _____

List members of household, birth date, relationship to patient, and income from each source; state whether income is per week, month, or year.

Name	Birth Date	Relationship	Income Wk/Mo/Yr	Total

(Continue on back, if necessary.)

Please provide a copy of your last (3) check stubs, a Tax return from prior year, or last (2) bank statements for income verification purposes.

If you have NO INCOME, please complete the following:

I, _____, do attest that I have no reportable income for my household.

Support Statement: My signature will certify that I, _____(supporter) of the above applicant, do provide all necessary essentials for living for the applicant and have done so for a period of _____ years/months (circle one).

_____ _____ _____

Signature of Supporter _____ **Phone #**

Address of Supporter

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in denial of this application. I understand that a credit report may be obtained or other measures may be taken to verify the information herein. I fully understand that Jasper Health Services, Inc. Patient Financial Assistance Program is a "Payer of Last Resort" and I hereby assign all benefits from any liability actions, personal claim injuries, tort settlements or any insurance benefits which may become payable for illness or injury for which Jasper Health Services, Inc. provided care.

_____ _____

Signature of Applicant/Guardian **Date**

Please complete the following if there is <u>INCOME</u> in the household:

Self-Employment
A tax return is also required if you are self employed. However if income for any member of household is from self-employment and you were **<u>NOT</u>** required to file a tax return, you may give information on business costs so that we can determine actual income to be counted. Write details on back of this sheet. This also includes any "odd" jobs. (Example: cutting grass, cleaning gutters, handyman work, etc…)

If you do not receive a check stub, a letter signed from your employer stating the number of hours routinely worked and pay rate will be sufficient.

Please remember to list **<u>ALL</u>** income on application including the amount in SSI, Food Stamps, etc.

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in denial of this application. I understand that a credit report may be obtained or other measures may be taken to verify the information herein. I fully understand that Jasper Health Services, Inc. Patient Financial Assistance Program is a "Payer of Last Resort" and I hereby assign all benefits from any liability actions, personal claim injuries, tort settlements or any insurance benefits which may become payable for illness or injury for which Jasper Health Services, Inc./PCC provided care.

_____ _____
Signature of Applicant/Guardian **Date**

FOR JHS, Inc. USE ONLY:

Number counted in Household: _____ Total Countable Income: _____
(Average monthly income for last year or past 3 months, whichever is more favorable.)
Verification of income supplied (if requested)? Yes _____ No _____
Determined: Eligible for free service _____ (Conditional _____ Pending _____)
Eligible for discount _____ (%) (Conditional _____ Pending _____)
Ineligible _____ Reason: _____
Date notice mailed: _____ Staff Signature: _____ Date: _____
Reconsideration: Result: _____ Date: _____
Date notice mailed: _____ Staff Signature: _____ Date: _____