USA HEALTH

Post Office Box 40010 | Mobile, AL 36640
(251) 434-3505

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION:

Patient Name: _____ SSN: _____

USA Account Number(s):_____

Date of Birth: _____ Employer: _____

Address: _____ City: _____ State/Zip: _____

Home Phone #: _____ Cell Phone #: _____

Marital Status: _____

SPOUSE/GUARANTOR INFORMATION (if different from above)

Name: _____ Relationship: _____

Address: _____ City: _____ State/Zip: _____

Date of Birth: _____ SSN _____ Employer: _____

Home Phone #: _____ Cell Phone #: _____

Marital Status: _____

HOUSEHOLD INFORMATION

Number in Household: _____, please list below (use separate sheet if necessary):

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

HOUSEHOLD INCOME

	Last 12 Months	Last 3 Months
Gross Household Income:	_____	_____

SOURCE OF ALL HOUSEHOLD INCOME:

Employment:_____ Unemployment: _____ Child Support: _____

SSI/SSD: _____ Other: (please specify):_____

I certify that the above information is true and accurate to the best of my knowledge. Furthermore, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available to pay for my hospital charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can judge my eligibility for financial assistance. USA Hospitals reserves the right to verify all given information with credit bureaus and any other persons or creditors they see fit. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE: FOR OFFICE USE ONLY

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ELIGIBILITY DETERMINATION

Patient Qualifies: Yes _____ No _____

The applicant 's request for financial assistance has been denied for the following reasons:

_____

_____

_____

_____

Date of Determination of Eligibility: _____ Date Applicant Notified: _____

Signature of Hospital Representative: _____