



PO BOX 1629 Attention: Financial Counselor Demorest Ga 30535  
 Direct Questions to HMC Financial Counselor: 706-754-3113 ext. 1118

**Application for Financial Assistance**

Date: \_\_\_\_\_ Account Number: \_\_\_\_\_

**Part 1: Applicant Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number (home) \_\_\_\_\_ Phone Number (cell) \_\_\_\_\_

**Part 2: Please answer the following questions**

1. Are you currently employed?  YES  NO
2. Have you applied for disability?  YES  NO
3. Have you applied for Medicaid recently?  YES, denied coverage  YES, still pending  NO

**Part 3: Household Information**

1. Are you a US Citizen?  YES  NO
2. Do you have any insurance, including Medicare or Medicaid, that may pay for these services?  YES  NO
3. What is the number of people in your home? \_\_\_\_\_
4. Do you receive food stamps? If yes, how much? \_\_\_\_\_

**Family Income Data:** List all Family members in Household under 18 years of age.

Name	Date of Birth	Social Security Number	Relationship to Patient

**Please read before signing your application.**

I CERTIFY that the information I have provided is true and accurate to the best of my knowledge. I will independently or with the assistance of hospital personnel apply for ANY and ALL Assistance which may be available through federal, state, local government and private sources to help pay this hospital bill. I will ASSIGN to the hospital provider ALL FUNDS received from federal, state, local government and private sources. I understand that the information which I submit is subject to verification by the hospital and subject to review by FEDERAL and/or STATE AGENCIES and others as required. **I understand that all applications for financial assistance are subject to verification of employment and other verification processes or resources which may be necessary in order to substantiate my financial status as seen fit by Habersham Medical Center. All information submitted will be kept confidential and used only for the purpose of assisting us with a decision to offer you financial assistance.**

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**