UPSON
Regional Medical Center

Application for Free and Reduced Charge Services

Patient: _____ Date(s) of service: _____
_____
_____

Name of Applicant: _____ Relationship: _____
Address: _____ Telephone No: _____
_____
_____

Please provide household member names and proof of income. If you are unemployed and have no income please indicate zero income. Proof of income can be the most recent check stub, a letter from the employer, or an income tax return.

Name of Person in household	Birthdate	Relationship	Income we/mo/yr	Income we/mo/yr	Income we/mo/yr	Total Income
1						
2						
3						
4						

If income of any member is from self employment you may give information on business costs so that we can determine actual income to be counted. Additional details or comments may be written on the back side of this application.

You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills and would not have to be counted.

Signature of Applicant: _____ Date: _____

****

FOR HOSPITAL STAFF USE

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 required) Yes _____ No _____
Determination: Eligible for free services: _____ Conditional: _____ Pending: _____
Eligible for discounted services: _____%_____ Conditional: _____ Pending: _____
Ineligible: _____ Reason: _____

Date notice mailed: _____ Staff Signature: _____ Date: _____
Reconsideration:
Result: _____ Date: _____