Application For Free and Reduced Charge Services Under
The Indigent Care Trust Fund Program
Upson Regional Medical Center
801 West Gordon Street
Thomaston, Georgia 30286

Guarantor:______________________
Address:______________________
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Name of Patient:______________________
Account #:______________________

Telephone No.:______________________

Please provide household members names and proof of income:

Name:	Birthdate	Relationship	Income (we/mo/yr)	Income (we/mo/yr)	Total Income

Please provide verification of income, such as three months pay check stubs, food stamps letter, most recent income tax return, etc. You may email the application and requested documents to our secure email at fa@urmc.org.

If income of any member is from self-employment, you must submit the current or last year's tax return including the Profit & Loss Statement so we may determine actual income to be counted.

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

Signature of Applicant:______________________Date:______________

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For Hospital Staff Only

No. Counted in household_____Total Countable Income:__________Verification of income supplied:Yes___ No_____

Determination:Eligible for free services:___Conditional?_____Pending?__Eligible for discount:__%__

Pending______________________Date notice mailed:______________________

Staff Signature:______________________Date:______________________

Reconsideration: Result:______________________Date:______________________