



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: [f\_Reg Guar Name Full]
[f\_Reg Guarantor Address1]
[f\_Reg Guarantor City], [f\_Reg Guarantor State] [f\_Reg Guarantor Zip]

Name of Patient: [f\_Reg Name Last First Rest]
Service Date: [f\_Bar Adm Svc Date]
Account #: [f\_Reg Account Number]

Telephone No.: [f\_Reg Guarantor Home Phone]

Please provide household members names and proof of income:

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

Three horizontal lines for household member information.

Please provide verification of income, such as three months' pay check stubs, most recent income tax return(s), wage summary, etc. You may email the application and requested documents to our secure email at fa@urmc.org. All required proof of income must be received within 30 days of the application date. Failure to do so will result in the application process being restarted.

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: \_\_\_\_\_