



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 Name:
 Guarantor Address:
 City: State: Zip:

Name of Patient:
 Service Date:
 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, 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: _____

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: _____