PATIENT NAME:_____

APPLICATION ISSUE DATE:_____

RETURN BY:_____

Dear Patient/Responsible Party.

We are providing this application, because you may qualify for our ***Financial Assistance Program.***

The attached form only applies to hospital bills, and does not include any other medical bills you may have; such as physician, radiology, ambulance, etc.

In order to be considered for a full or partial assistance, you **must** complete the Financial Assistance Application. The responsible party **must sign all applicable documents,** and return the completed **witnessed** application within fourteen (14) days of receipt.

Non compliance will result in automatic denial.

All Patients: It is necessary for you to provide us with the below supporting documentation. If, for any reason, you cannot provide us with the requested information or if it does not apply to you, please explain beside each item.

- Signed Federal Tax Return (previous year) or electronic PIN # showing filing. If no return was filed in previous year, an explanation must be given. Must be prepared to explain dependants claimed on tax return_____
- Supporting W-2 _____
- Supporting 1099's _____
- Current check stub(s) for each household member employed with year to date total.(If previously employed in past 12 months but no longer, you must attach documentation to support last date of employment) _____
- Bank checking / savings statements (current month plus past 5 months) _____
- Food Stamp notice (current month plus past 11 months) _____
- Disability Acknowledgment / Denial Letter _____
- If you are not working due to having applied for disability but have not been approved, you must attach a letter from your physician stating why you are unable to work _____
- Social Security / VA/ Pension benefits (current month plus past 11 months) _____
- If married but separated, you must attach a written statement, signed and dated by the spouse, then notarized outlining details regarding separation date.
- Child support / Alimony payments (current month plus past 11 months) _____
- Additional documentation to support rental income, worker's compensation and/or unemployment Benefits (current month plus past 11 months) _____
- If seeking employment, we need the employer's business name, address and phone number of last 3 employers that you have applied for employment including the date you applied _____
- Signed and dated letters from any family members and/or friends that are giving you financial support outlining the amount they give you, when it was given and why _____
- Pell Grant income (if applicable)

Once the application is completed accurately and all requested documents are attached, your file will be reviewed and a determination will be made resulting in a eligible or denial letter. If you have any questions regarding the application process, please feel free to contact Customer Service at 334-418-4380.

Please return the Financial Assistance Application and any required documentation back to the Customer Service Representative at Vaughan Regional Medical Center. You may mail your application to:

Vaughan Regional Medical Center
Attn: Lisa McIntyre
1015 Medical Center Parkway
Selma, AL 36701