Washington County
REGIONAL MEDICAL CENTER

Instructions for Completing Charity Care Application

1. Completely fill out the form.
2. Mail completed application and supporting documents to the address below or bring your application and supporting documents to:

   Washington County Regional Medical Center
   PO Box 636
   Sandersville, GA 31082
   Attn: Financial Counselor

   If submitting documents separate from the application, please include a cover letter that provides the patient's name and date of birth in order for us to match them with the application.
3. Attach a copy (do not send originals) of the following documents:

   Required documents for all applications:

   A. Proof of household income must be at least one of the following:

   - ☐ A copy of four most recent pay stubs of all employed in the household. If no pay stub available, please provide a notarized letter from employer.
   - ☐ If self-employed, a copy of most recent federal income tax filed.
   - ☐ Proof of worker's compensation, sick leave, disability compensation, welfare, or social security retirement (SSI not included in income determination).
   - ☐ If you have no income at this time, provide a signed and notarized letter from the person who provides room and board for you and your family, if applicable.

   B. Proof of home address must be at least one of the following:

   - ☐ Valid Georgia driver's license
   - ☐ Georgia identification card
   - ☐ Current utility bill
   - ☐ Lease or rent receipts showing evidence of county of residence
   - ☐ County property tax assessment
   - ☐ County food stamp letter
   - ☐ Voter registration card

   If applicable, also submit these documents:

   - ☐ If you are not married but there are children in common, you must provide entire household income. Any child support or alimony received must also be included.
   - ☐ If you are still legally married but separated, you must provide legal documentation of separation or spouse's income.
   - ☐ If you lost your job within the last three months, you are required to provide a separation letter from your past employer. Additionally, you must provide a letter from your local Georgia Department of Labor Career Center specifying whether or not you are receiving unemployment benefits.
   - ☐ If you have listed any children on your application other than biological or stepchildren, you must provide legal documentation to this effect.

You will receive a response from us in the mail whether approved or denied within 30 days. If you do not receive notification within 30 days, you are welcome to call (478) 240-2021 for a status update on your application. If you feel that it is necessary to meet with a Financial Counselor, the office is open Monday-Friday from 8:30 AM-5:00 PM. No appointment is necessary.

By completing this application, you agree:

- ☐ To apply for Medicaid or any other type of potential coverage available to pay for your care.
- ☐ That all of the information provided is accurate and complete and will be verified. Providing false information, including incomplete information or documentation, will result in a denial of charity. Additionally, NGHS reserves the right to reverse any charity if information is found to be false after charity has been approved.
- ☐ To provide all information within 30 days of submitting an application, or the application will be closed and denied.

Application for Charity Care

Patient: ______________________________ Date of Service: ________________________
____
____

Name of Applicant: _____________________ Relationship: __________________________
Address: ______________________________ Telephone Number: _____________________
____
____

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 backside 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.

Signature of Applicant: _______________________________________ Date: _____________

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FOR HOSPITAL STAFF USE

Number 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: _____________