ACCOUNT NUMBER:

163 Hospital Dr
Toccoa Ga 30577
706-282-4200

PLEASE FILL OUT AND RETURN WITH ALL SUPPORTING DOCUMENTS WITHIN 30 DAYS OF DISCHARGE.

STAFF USE ONLY

IN HOUSEHOLD_____TOTAL INCOME _____INCOME VERIFIED? YES NO

SENT FOR PROOF OF INCOME_____DATE_____

ELIGIBILITY – FREE SERVICE_____ DISCOUNT_____ PENDING _____

INELIGIBLE_____REASON_____
HOSPITAL STAFF SIGNATURE

_____DATE_____

APPLICATION FOR FREE OR REDUCED CHARGES

To Apply

1.) Complete and sign this application.
2.) Provide ALL documentation required (Listed on page 3 of this application)

If you have any questions or need assistance, please call 706-282-4200 ext 2003 anytime Monday-Friday 8:00-4:30

YOUR APPLICATION WILL NOT BE ACCEPTED IF YOU DO NOT PROVIDE ALL APPLICABLE DOCUMENTS LISTED ON PAGE 3

The results of your application will be sent via mail once a decision has been reached. Based on income guidelines you may be eligible for free care or a reduced rate.

This application does not cover physician fees, radiology reading fees, anesthesia charges, or Wound Care center accounts.

This application also does not cover elective procedures or non-emergent surgery.

Supporting Documents

PLEASE BRING THE FOLLOWING DOCUMENTATION WITH YOUR APPLICATION!

The list below applies to all members of your household, if an extended family member resides with you but is not your legal guardian or responsible for paying your medical bills they are not considered a member of your household and their income does not count toward the total household income.

1.) Income from Government sources:

- Government or pension checks
- Food stamps, social security, disability, retirement, child support, alimony, or Worker's Compensation, dated 2023
- Denial letter from Medicaid dated 2023 (**IF YOU HAVE MEDICAID YOU ARE *NOT ELIGIBLE* FOR THIS PROGRAM)**

  Until your denial letter arrives, you must provide proof you have applied (i.e. a copy of the front page of your Medicaid application)

2.) Federal Taxes:

- 1040 Tax Return for 2022, if filed.
- W-2 if no tax return
- If no W-2 or Tax return we need a wage inquiry from Department of Labor

3.) Proof of Identification:

- Legal Georgia Driver's License OR Legal Georgia ID card
- If you have none of these, please let us know. We DO NOT discriminate of the basis of national citizenship, nationality, ethnicity, race, gender, sexual identity, etc.

All of the above must be submitted to Stephens County Hospital, we cannot accept an application that is incomplete. Please contact Stephens County Hospital Financial Services if you have any questions.

Application

Name:_____ Date: _____

Date of Birth: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Total # of Household Members (including yourself): _____

Are You Employed? ___Y / N_____ If Yes, Where? _____

Do You Have Any Healthcare Insurance? _____

LIST THE **PATIENT'S NAME**, MEMBERS OF THE PATIENT'S HOUSEHOLD, THEIR RELATIONSHIP TO THE PATIENT, AND EACH PERSON'S INCOME.

NAME	BIRTHDATE	RELATION	WEEKLY INCOME	MONTHLY INCOME	ANNUAL INCOME
		SELF			

IF YOU HAVE AN EXTENDED FAMILY MEMBER LIVING WITH YOU WHO IS NOT YOUR LEGAL GUARDIAN AND IS NOT RESPONSIBLE FOR REPAYING YOUR MEDICAL BILLS DO NOT COUNT THEIR INCOME OR INCLUDE THEM AS PART OF YOUR HOUSEHOLD.

BY SIGNING BELOW I VERIFY THAT ALL INFORMATION IS CORRECT AND COMPLETE. I UNDERSTAND THAT ALL INFORMATION PROVIDED TO STEPHENS COUNTY HOSPITAL WILL BE KEPT CONFIDENTIAL AND CANNOT BE RELEASED WITHOUT MY CONSENT.

SIGNATURE OF APPLICANT

_____DATE_____

Declaration of Income

☐ I declare that I have been working and receiving payment in the amount of $_____

Every (circle one): DAY WEEK TWO WEEKS MONTH

☐ I have no paycheck stubs or other documentation to prove my earnings.

☐ I have provided a list of people I have worked for in the past three months for verification.

LIST NAME(S) OF EMPLOYERS, CONTACT NUMBER(S), AND AMOUNT PAID PER MONTH

_____
_____
_____
_____
_____

◆ **OR** ◆

☐ I declare I have no employment and do not have any income of any kind.

I have provided a list of people who have helped with my living expenses.

LIST NAMES AND CONTACT NUMBER(S) OF ANYONE WHO HAS HELPED YOU BY PAYING RENT, BILLS, GROCERIES, ETC.

NAME	PHONE	WHAT WAS/IS PROVIDED	AMOUNT PAID

CERTIFICATION OF INFORMATION

☐ I certify that all income information provided on this application is complete and true to the best of my knowledge.

☐ I certify that I do not have Medicaid.

☐ I understand that if I knowingly give false information on this application that I will be immediately denied access to free or reduced charges and subject to possible legal action.

Patient Signature:

_____ Date_____

Stephens County Hospital

Medicaid Denial Letter and/or Food Stamps Statement

In order to qualify for free or reduced charges we need to know that you DO NOT qualify for Medicaid benefits.

Our local DFCS office has closed, so you must apply in person at one of the following addresses, or call the number below, or apply online at **www.gateway.ga.gov**

Homer DFCS
154 Windmill Farm Rd.
Homer, Ga 30547
1 (706) 677 – 2272
Hours: Tuesday-Thursday 9am-3pm

Clarkesville DFCS
1045 Grant St
Clarkesville, Ga 30523
1 (706) 754 – 2148
Hours: Monday-Friday, 8am-5pm

GA DFCS Call Center
(To apply over the phone—early morning is the best time to call)
1-877-423-4746
Menu Option Choices:
1 – "English"
2 – "No Fraud"
1 – "Constituent"
2 – "Apply For Benefits"
1 – "Verify"

If we do not receive this documentation from you within 4-8 weeks we will have to deny your application. Please remember, it takes 4-6 weeks from the time you apply for the documents to be mailed out from DFCS.
In the meantime we need proof you have applied, such as: a printed copy of the front page of your application, or a printed copy of a screenshot of your online application, and/or your case number.

Patient Signature:
_____ Date: _____

Declaration of Monthly Income

Patient Name: _____ D.O.B.:_____

Spouse/Partner Name:_____D.O.B.:_____

Address:_____

City:_____ State:_____ Zip: _____

Phone #: _____ Alt. Phone #: _____

Family Income Information

Please list all family members within household, and their monthly income (if applicable)

	Name	Monthly Income
Self		
Spouse/partner		
Children *(under 18)*:		
***Other dependent*s:**		
(i.e. live-in grandchildren, foster		
children, etc.)		

Other Income

(Please list the below monthly incomes if applicable)

	Monthly Income
Alimony/child support	
Social Security/Pension	
Public assistance/Food stamps	
Unemployment/Worker's Comp	
Other Sources	

Total Income: _____

The undersigned hereby acknowledges that the information in this statement is true and correct to the best of their knowledge.

Patient Signature:

_____ Date:_____