BON SECOURS HEALTH SYSTEM
FINANCIAL ASSISTANCE APPLICATION Date Sent ___________

Facility **SC Physician Services** Account #_______________________________
Patient Last Name________________________ First________________________________ MI___________
SS#_________________ Date of Birth_____________ Marital Status___________Phone#_____________
Patient Address____
Employer______________________________ Spouse's Employer____________________________________

Family Members (List spouse and dependent children under 18 years, or as listed on your taxes and their date(s) of birth):

Name	***Date of Birth***	**Name**	**Date of Birth**
1. ____________________________	/ _______________	4. ___________________________	/ ________________
2. ____________________________	/ _______________	5. ___________________________	/ ________________
3. ____________________________	/ _______________	6. ___________________________	/ ________________

APPLICANTS MUST SUBMIT ALL REQUIRED DOCUMENTS IN THE SAME MAILING TO:
Bon Secours Financial Assistance Program
P.O. Box 742431
Atlanta, GA 30374-2431

Please answer each question and provide the information requested
UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE
DECISIONS WILL BE RENDERED WITHIN 60 DAYS OF RECIEPT OF COMPLETED APPLICATION AND PARTICIPATION WITH OUR VENDOR

Please answer all questions listed below		**If YES, please provide the following for EACH member of the household receiving the benefit.**
Is any member of your household **self-employed?**	❑ YES ❑ NO	COMPLETE TAX form(s) including business taxes from the most recent tax year and latest quarterly filing listing income for quarter
Is any member of your household **employed**?	❑ YES ❑ NO	3 most recent pay stubs or signed letter from employer
Is any member of your household receiving **unemployment benefits?**	❑ YES ❑ NO	Benefit letter or Unemployment printout from State website
Is any member of your household receiving **Social Security**?	❑ YES ❑ NO	SS benefit letter or complete bank statement if direct deposited
Does any member of your household receive a **Pension or Retirement**?	❑ YES ❑ NO	Pension/Retirement letter or complete bank statement if direct deposited
Does any member of your household receive **SNAP benefits**?	❑ YES ❑ NO	SNAP Letter
Does any member of your household receive a **Child Support**?	❑ YES ❑ NO	Court ordered document or letter from non-custodial parent
Does any member of your household own **rental or investment property**?	❑ YES ❑ NO	Rental agreement/documentation listing income amount
Does any member of your household have **other sources of Income**?	❑ YES ❑ NO	Stocks, Bonds, CD's additional property, etc… Attach current statement(s)
Does any member of your household have a **checking, savings or money market account** ?	❑ YES ❑ NO	Attach complete copy of current 30 day statement for each account

NO INCOME: ❑ YES ❑ NO

If your household is claiming no income you must have the person providing your food, shelter, and daily living expenses sign below and indicate which type of assistance they are providing

*I certify that I (**name**)______________________________________(**phone number**)_____________________________*
provide food, shelter, and daily living expenses for the patient listed above and/or income of $______________Monthly
Assistance provided:____
Signature_________________________________***Relationship***___________________________***Date***____________

Applicants on a VISA must provide a copy of all insurance, financial, and/or sponsorship information provided to obtain the VISA.

>>>Continued<<<

BON SECOURS HEALTH SYSTEM

BON SECOURS HEALTH SYSTEM
FINANCIAL ASSISTANCE APPLICATION

Patient Last Name__________________________________ First____________________________ MI___________

Personal Asset Value List

Annual Household Income	_____________	CD's (Cash Value)	_________________________
Cash on Hand/Money in Bank/Savings Acct(s)	_____________	Primary residence (Cash Value)	_________________________
Monthly Rent	_____________	Other Real Estate (Cash Value)	_________________________
Monthly Mortgage payment	_____________	401k (Cash Value)	_________________________

Was treatment for this service due to an accident? Yes________ No____ (**Financial Assistance program does not apply to treatment related to work injuries, cosmetic procedures or flat rate procedures, accidents or other treatment for which you receive compensation for your medical bills, pain and suffering and other damages).**

Do you have health insurance ❑ YES ❑ NO (If YES, please provide further information below)

1. Insurance Name____________________________ Policy Holder Name ______________________ Policy#__________________
2. Insurance Name____________________________ Policy Holder Name ______________________ Policy#__________________

I hereby request that Bon Secours Health System Inc., make a written determination of my eligibility for financial assistance. I understand that, if the information which I submit is determined to be false, such determination may result in a denial of my application and that I may be liable for charges for services provided. I certify that the above information is true, complete, and correct to the best of my knowledge. I acknowledge that cooperating with the eligibility screening vendor is required to be considered for financial assistance.

Additional Comments

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Signature of Responsible Party: ____ Date: ________________

Bon Secours Health System Inc., reserves the right to validate information reported in the Financial Assistance application, such efforts to validate personal income or lack thereof, will be conducted in such a manner as to maintain the utmost confidentiality and in no way generate any report by any credit bureau agency that could adversely affect the privacy of the applicant.

If you need additional assistance, please visit a financial counselor at your local Bon Secours hospital or call our Customer Service Department.

Phone (864)255-1902
Monday – Friday 8:00 AM to 5:00