Warm Springs Medical Center
5995 Spring Street, PO Box 8
Warm Springs, GA 31830
(706) 655-3331 www.warmspringsmc.org

Application for Indigent Care Trust Fund Program

(All fields must be completed before application can be processed)

Patient Name: ____________________________ **Date of Birth (DOB):** ________________ **Date:** _______________

Name of Applicant: ________________________________ **Relationship to Patient:** ________________________

Address: ___________________________________ **City:** ____________________**State:** _________**Zip:**__________

How long have you lived at this address? _______ Years _______ Months **Phone:** _________________________

Are you employed: ________ **Employer Name:** ____________________________ **Work Phone:** ________________

Are you a resident of Georgia? _________ **Total household Size:** _________ **Total # of dependents:** __________

List each member of household, date of birth, age, relationship to patient, and gross income from each source; state whether income is per week, month, or year:

NAME	DATE OF BIRTH	AGE	RELATIONSHIP	TOTAL GROSS INCOME (wk/mo/yr)

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. Write details on the back of this sheet.

(Note to applicant: 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. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills, and would not have to be counted or report income.)

If you do not have any income for your household, please explain your situation in the space provided below:

This verification will be valid for six (6) months unless any changes occur.

Please provide ONE of the following (required)

- ☐ Applicant and/or Spouse's three (3) most recent check stubs OR a current pay stub with year-to-date total
- ☐ Applicant and/or Spouse, a current wage inquiry for each person from the Georgia Department of Labor
- ☐ SSI, disability, child support, retirement, pension, VA benefits, workers compensation, or alimony statements or bank statements showing direct deposits of the same for patient/application and spouse
- ☐ Copy of last year's federal income tax return (including Schedule C for self-employed) or a statement from the person paying the bills.

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STATEMENT

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information I have submitted is subject to verification, including credit agency reporting agencies, and subject to review by Federal and/or State agencies and other as required. I AUTHORIZE by employer to release to WSMC provider by proof of income. I UNDERSTAND that if any information I have given proves to be untrue, WSMC will reevaluate by financial status and take whatever action becomes appropriate and I will be liable for payment of charged for all services rendered. I agree to pay any remaining balances after financial assistance adjustments are made. I understand that this request for financial assistance may not pertain to other health care providers.

Signature of Applicant ____ Date ___________________________

Please send completed and signed application with supporting documentation to:

Warm Springs Medical Center
Attn: Business Office
P O Box 8
Warm Springs, GA 31830

If you need any assistance with this application, information or process, please call the Registration Supervisor at 706-655-9297 or Business Office at 706-655-9225 for further assistance.

Allow 15 business days for processing. A written notice will be mailed with the final decision.

For Hospital Staff Use

Number counted in household ___________________________ Total Countable Income _______________________

(Average income for last year or past 3 months, whichever is more favorable)

Verification of income supplied (if requested)? ☐ Yes ☐ No

Determination: ☐ Eligible for free services ☐ Conditional? ☐ Pending

☐ Eligible for discount _____% ☐ Conditional? ☐ Pending

☐ Ineligible Reason ____

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Date notice mailed ____________ Staff Signature ____________________________ Date ____________________

Reconsideration ____________ Result _________________________________ Date ____________________