Financial Assistance
Helping Hands Program

It is our pleasure to extend financial assistance for those unable to pay for emergent or non-emergent hospital services, provided those services are deemed medically necessary.

This application and required supporting documentation may be completed for consideration within sixty (60) days of the first post-discharge statement.

Documentation accepted for proof of income purposes includes the following:

- State and Federal Income Tax Returns for most recent calendar year
- Employer pay stubs (for the prior 60 days)
- Bank Statements for the past two months
- Documentation of other income sources

Failure to provide the required documentation may delay processing, and as a result, the file may be closed. All requested items must be returned within ten (10) days of notice of an incomplete application packet. It is the patient or guarantor's responsibility to provide us with a valid mailing address for all correspondences, including notices of approval or denial.

Application assistance is available onsite at the hospital, or you may contact the Helping Hands Financial Assistance Office at (912) 754-0496 or email financialassistance@effinghamhospital.org.

Please remit all applications and supporting documents to:

Effingham Health System
Attn: Helping Hands
P.O. Box 386
Springfield, GA 31329

The Helping Hands Financial Assistance policy as well as a Plain Language Summary of the assistance program is available for reference on the EHS website located at www.effinghamhealth.org.

Effingham™ HEALTH SYSTEM

Financial Assistance
Helping Hands Program Application

Patient Name: _____ **SSN:** _____

Guarantor Name: _____ **Account No.:** _____

Telephone #: _____

Physical Address:	**Mailing Address:** (If different than physical)

General

1. Do you have Medicare or Medicaid? (yes) (no)
    a. If yes, please provide a copy of identification or ID#_____
2. Have you ever applied for Medicare or Medicaid? (yes) (no)
    a. Date and results? _____
3. Do you have other medical insurance active on the dates of services? (yes) (no)
    a. If yes, please provide a copy of identification or ID#_____

Household Income

4. How many dependents live in household? _____
5. Is there anyone who assists with your bills? (yes) (no)
    a. If yes, please provide the name:_____
6. List the household members, including date of birth, relationship, and income: *(Please note: the applicant is not required to report a household member who is **not legally responsible** for the patient's medical bills.)*

Name	DOB	Relationship	Income	Frequency

Name	DOB	Relationship	Income	Frequency

Total # in Household_____ Total Monthly Household Income_____

7. Please provide all income sources that apply and provide monthly dollar amount:

Income Source	Y / N	Total Monthly Amount
Wages received from employer	Y / N	**$**
Self-employed wages	Y / N	**$**
Public Assistance: Food stamps AFDC	 Y / N Y / N	 **$** **$**
Social Security	Y / N	**$**
Unemployment Benefits	Y / N	**$**
Strike Benefits	Y / N	**$**
Alimony	Y / N	**$**
Child Support	Y / N	**$**
Military Family Allotment	Y / N	**$**
Pension	Y / N	**$**
Interest / Dividends	Y / N	**$**
Other Income Source:_____	Y / N	**$**

Total Monthly Income **$_____**

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Disclosure

I certify that the above information is true and correct to the best of my knowledge. I understand that I will be guilty of deceit and/or fraud if I have knowingly answered these questions untruthfully. Effingham Health System has my permission to verify this information provided with agencies, companies, or employers listed in this application. I further understand this application does not guarantee or constitute assistance, nor is this a contract which is binding for Effingham Health System.

_____ _____

Applicant's Signature **Date**