McLeod Health

The Choice for Medical Excellence

Date: _____

Financial Assistance Case: _____

Account Number: _____

Dear: _____

The Hospital Charity Program provides uncompensated healthcare to those who qualify. Charity will be approved or denied according to the guidelines established by McLeod Health.

For more information regarding Financial Assistance offered by McLeod Health, please visit our website www.mcleodhealth.org.

Please return the signed application along with the information requested using one of the following methods:

- Return to a member of our McLeod Registration Staff or a McLeod Financial Counselor
- Upload your documents via McLeod MyChart to your Financial Assistance case
- Fax documents to: 843-944-8447
- Email documents to: eligibility@mcleodhealth.org
- Mail documents to:
  McLeod Health Support Services
  ATTN: Patient Access
  2210 Enterprise Drive
  Florence, SC 29501

Your application will be reviewed for financial assistance, and you will be notified of a decision. If approved, adjustments will apply to balances in accordance with our Financial Assistance Policy.

If you have any questions, please do not hesitate to contact us at any of the numbers listed below:
(843) 777 - 8550

Sincerely,

McLeod Health

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HOSPITAL CHARITY CHECK LIST

Phone: (843) 777-8550

Patient Name: _____ Date: _____

Financial Assistance Case #: _____ Account Number: _____

Below you will find a list of requested information. **We must receive all the information that applies to you before we can process your application for Hospital Sponsored Charity.** Thank you in advance for your cooperation.

	Patient	Spouse
Item		
Income Related Documents		
Application (Complete and Sign)		
Copy of **your most recent Federal Tax Return, W2 or final pay stub from the year prior** • If self-employed: **Include schedule C** • If you did not file taxes in the previous year**, please submit a note stating why**		
Last 4 recent pay stubs showing gross pay or wage statement from employer stating gross pay. • If self-employed: **provide quarterly financial statement** • If not employed: **complete employment statement**. If you worked during the current year, send the most recent pay stub with year-to-date income. • If married and spouse is not employed: **complete spouse employment statement**. If spouse worked during the current year, send the most recent pay stub with year-to-date income.		
Recent Statement from: Social Security, Disability, AFDC, Child Support, Retirement, Unemployment, etc.		
Most Recent Detailed Bank Statement		
SNAP benefit letter		
Living Arrangement Documentation		
If you own property: **Property Tax Notice**		
If you rent: **Rent Receipt**		
If you (and spouse) have no income or live with other than a spouse: **Food and Shelter statement completed by person with whom you are living**		

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Application for Hospital Sponsored Charity

Patient Name:_____ Email Address: _____

Address: _____ Date of Birth: _____

City and State _____ Primary Phone #: _____

Zip Code: _____ Patient SSN: _____

PATIENT/FAMILY INFORMATION:

(Please complete and answer all questions)

Marital Status: _____

Household Monthly Gross income: (Any wages earned, AFDC, SSI, VA, Social Security, Child Support, Alimony, Disability, etc. received by any Family Member.) **$** _____

Number of Family Members: (A group of two or more people related by birth, marriage or adoption who live together; all such related people are considered members of one family.) _____

Number of Family members under 19yrs: _____

Do you have any 3rd party claims? Yes / No

Has a physician deemed you disabled? (Any condition that will keep you from performing any type of work for more than 365 days.)
Yes / No

Please Circle your work status: Self-employed / W2 employee / Work for Cash / Unemployed / Retired

Do you receive any other income? (Social Security, Child Support, etc.) Yes / No

Are you Pregnant? Yes / No

Living situation (Please circle one): Own a home / rent / live with someone / homeless

Do you have any bank accounts in your name, your spouse, or both? Yes / No

I certify that the above information is true and accurate to the best of my/our knowledge. Further, I will make application for any assistance (Medicaid, Insurance, or any other funding) which may be available for payment of my hospital charges. I will assign to or pay McLeod Health the amount recovered for hospital and professional charges. If any information I have given proves to be untrue, I understand that McLeod Health may re-evaluate my financial status and take whatever action may become appropriate for collection of unpaid balance.

Date Signed: _____ Applicant's Signature: _____

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EMPLOYMENT STATEMENT

Date: _____

I, _____, affirm that I have not been employed since _____, nor have I received income from any employment since the date stated above.

_____

Signature of Patient

McLeod Health

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SPOUSE EMPLOYMENT STATEMENT

Date: _____

I, _____, affirm that I have not been employed since _____, nor have I received income from any employment since the date stated above.

_____

Signature of Patient's Spouse

McLeod Health

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FOOD AND SHELTER STATEMENT

(To be completed by the person who assists you financially)

Date: _____

I, _____ provide food and shelter for _____.

My relationship with this person is _____. By signing this paper, I am in no way responsible for any bills incurred during this hospital stay.

_____

Signature of person who provides Food and Shelter