

Applicants Name: _____ DOB: ____/____/____

Applicant's Address: _____ City: _____ State: ____

Applicant's Home Phone #: (____) _____ Cell (____) _____

Acct # : _____ Today's Date: _____

SSN: ____/____/____

Information Supplied by: _____ Relationship to Patient: _____

Medical Center of Central Georgia Financial Assistance Application

SECTION 1 – INSURANCE INFORMATION

- 1. Does the applicant have insurance? Yes No
- 2. If yes, Company Name: _____
 Name of Insured: _____
 Relationship: _____
 ID# _____ GRP# _____ **(obtain copy of front and back of insurance card)**
- 3. Is the applicant pregnant OR a minor child under the age of 19 years? Yes No If yes, applicant may be eligible for Medicaid or CHIP
- 4. Is the applicant between the ages of 18 and 26? Yes No If yes, obtain parents name, employer and insurance information along with copies of cards
 Parent Name : _____
 Phone # _____
 Employer: _____
- 5. Is the applicant a citizen or permanent resident of the United States? Yes No If no, patient may be eligible for Emergency Medicaid
- 6. Has the applicant applied for insurance offered through the Affordable Care Act at www.healthcare.gov ? Yes No

- 7. If applicant is eligible for Supplemental Security Income or Disability, do they wish to apply? Yes No
- 8. Has applicant ever applied for Medical Assistance SSDI or SSI in the past? Yes No If yes, which programs and location (county/state)?

_____ If yes, does applicant have an attorney? Yes No If yes, name / address / phone number: _____

SECTION 3 – HOUSEHOLD INFORMATION

- 9. Is spouse in the home? Yes No If no spouse, then single parents may investigate Aid for Dependant Children Medicaid
- 10. Number of persons living in household _____ (List each individual below. If additional room is needed, attach paper with information)

Name	Relationship	Age	Employer	Yearly Income Before Taxes

List the names and ages of all your children under 18 not living in the household: (if patient is approved for SSI their child may also receive a check)
Name Age Address Living with:

11. Is applicant a Veteran? Yes No (If yes, investigate VA benefits. Contact local V.A. hospital.)
12. Has applicant, spouse or parents left a job within the last 18 months in which health benefits were provided? Yes No
- a. If yes, applicant may qualify for COBRA benefits. Enter previous employer's information below.

Occupation _____ Time employed there _____ Rate of pay _____

Previous Employer _____ Address _____ Phone Number _____

If a Disability referral is being made, complete the information below.

1. Is the applicant Single Married Divorced Widowed - **Maiden Name:** _____

2. Would the applicant prefer an in office or telephone interview to apply for Disability/SSI benefits?

In office (**preferred**) Telephone interview : (_____) _____ phone # for interview

Last grade completed in school : _____ Date last worked: ____/____/____

Place of Birth: City _____ State _____ Mother's Maiden Name _____ Father's Name _____

Spouse's Name _____ Spouse's DOB _____ Spouse's SSN _____

Spouses Employer _____ Address _____ Phone Number _____

Occupation _____ Time employed there _____ Rate of pay _____

Current Monthly Household Income (earned or unearned) _____ Type of income (IDA, TANF, child support, spouses income, work) _____

Life insurance carrier _____ Cash Value _____ Pension _____ Amount _____

SECTION 4 – ASSET & LIABILITY INFORMATION

Account:	Account #	Bank	Account Holder	Current Balance
Checking				
Savings				
Trust Fund				
IRA				
Certificate of Deposit				
Food Stamps		N/A		
Real Estate Owned		Rental Income: \$	Address:	

Expenses: Rent? Yes No Amount: _____ Name on lease: _____

Own? Yes No Mortgage amount: _____ Name on Title: _____

Automobile(s): Yes No Make/ Model _____ Year _____ Pymt: _____ Balance: _____

Yes No Make/Model _____ Year _____ Pymt: _____ Balance: _____

TPL Screening/Information

Motor Vehicle Accident:

1. Is your visit the result of a motorized vehicle accident? Yes No Circle one: Auto Motorcycle ATV Moped Pedestrian Bicycle
2. Has a police report been filed? Yes No Were you the driver Yes No Were you a passenger Yes No
3. If yes, name of Law enforcement agency: _____ Case # _____
4. Has an insurance claim been filed? Yes No Insurance Company: _____
Agent Name: _____ Phone #: _____
Name of Insured: _____
5. Date and time of accident/injury: _____ Location of the accident/injury (specific address) _____
6. Describe how the accident/injury occurred: _____

7. Do you carry personal injury coverage on your personal auto insurance? Yes No
8. Name of your auto insurance company, address, phone number and policy number: _____

9. Is another party responsible for the accident/injury? If yes, please provide their name and address: _____

10. Is another insurance company involved in the case? If yes, please provide name and phone number: _____

Work Related Accident:

1. Did the accident/injury occur at work: Yes No Date and Time of Injury: _____
2. Injured person's place of employment at time of incident: _____
3. Was an incident report filed with employer? Yes No
4. Name of Supervisor / Contact Person: _____ Phone: _____
5. Was the incident reported to the Police Department? Yes No
6. If yes, name of Law Enforcement Agency: _____ Report number: _____

Victim of Crime:

1. Is applicant a victim of crime? Yes No
If yes, then a police report must be filed within 72 hours of the crime to pursue Crime Victims Program.
2. Date and Time of Injury: _____ Location of the accident/injury _____
3. Has a police report been filed as result of crime? Yes No If yes, name of Law Enforcement Agency: _____
4. Describe how the accident/injury occurred: _____

Legal Action (Answers required for all TPL listed above)

1. Have you commenced legal action? Yes No Do you intend to take legal action? Yes No
2. If you have consulted an attorney, please furnish name, address and phone number: _____
3. Have you been contacted by an attorney or representative of an insurance company about this matter? Yes No
4. If yes, please furnish name address and phone number: _____
5. Have you received a settlement for injury? Yes No If yes, provide: Amount of settlement: _____ Date of settlement: _____

SECTION 5 – FACILITY & REVIEWER INFORMATION

I certify that the information provided to the interviewer is accurate to the best of my ability.

Applicant's Signature

Date

Reviewer's Name and Title

Date

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Reviewer's Phone Number