Williamsburg Regional Hospital
500 Nelson Boulevard
P.O. Drawer 568
Kingstree, SC 29556

Phone: 843-355-8888 **Fax: 843-355-0152**

Williamsburg Regional Hospital Financial Assistance/Charity Form

Patient Name: _____ DOB_____

Address: _____

_____

Account# _____
With Dr. _____

Dear Patient:

Enclosed, please find the Check List on page 3 which list the documents that are required for the financial assistance/charity application. These forms need to filled out as completely as possible, signed, and returned to us within 30 days of the date of your first bill. This application cannot be completed without verification of income and liquid assets.

We will need to have these forms and documents within 30 days of the date of the first bill in order to consider your application for financial assistance/charity.

Thanking you in advance for your prompt attention to this matter.

Sincerely,

_____ _____

Williamsburg Regional Hospital Staff Person Telephone Number

_____
Date

Williamsburg Regional Hospital Financial Assistance/ Charity Form

Expenses:

Enter the monthly expense amount for the following:

Mortgage/Rent $_____

Automobile $_____

Utilities $_____

Medical:

- Insurance $_____
- Medications $_____
- Physician/Hospital $_____
  (Name of Provider: _____)

Insurance (home, life, auto) $_____

Credit Cards (list any and balance on each)

_____ $_____

_____ $_____

_____ $_____

Other: Please list your monthly expenses not included in above:

_____ $_____

_____ $_____

_____ $_____

Signed: _____ **Date:_____**

I certify that I have read or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding any situation, I am liable for prosecution for fraud. By my signature, I authorize release of any information needed to determine my eligibility for charity. I understand that qualification for charity is limited to 30 days and that at the end of the eligibility period, I must reapply, in order to continue to receive applicable discounts. Services discounted are limited to those deemed medically necessary. Applicants qualifying for less than 100% discounts will be required to pay the remaining balance in full or have it approved.

Williamsburg Regional Hospital Financial Assistance/Charity Form Checklist

_____A copy of patient's last two paycheck stubs

_____Proof of income for guarantor and spouse (includes common law), for at least three months prior to patient's services

_____Unemployment benefits letter or check stubs

_____Social Security benefits & SSI award letter

_____Department of Social Services grants and/or amount of food stamps

_____Written statement of child support if this applies to guarantor

_____Copy of mortgage statement

_____A letter of support from the person who provides food and shelter

_____Proof of food stamps

_____A copy of guarantor's checking and savings account statements, certificates of deposit, annuities, trusts, mutual funds, stocks, bonds, IRA's, 401K, 403b, retirement accounts, etc.

_____A copy of photo ID

_____Complete Charity Form

_____A copy of patient/guarantor current year's Federal 1040 tax return & attachments

_____If patient was not approved for 100% charity discount, do you have a payment Agreement with patient for their responsibility?

Williamsburg Regional Hospital Financial Assistance/ Charity Form

Demographic Information:

Patient Name: _____ Account #:_____

Responsible Party/Applicant: Home Phone: _____

Name: _____ Marital Status: _____

Address: _____ SSN: _____

_____ Employed By: _____

If not working, when was your last day of Employment? _____

Insurance Information:

Do you have Health Insurance? Yes_____ No_____
(Medicare, Medicaid, other)
I yes, Insurance company and policy number
Name: _____ Policy# _____
Name: _____ Policy# _____
Name: _____ Policy# _____

Is treatment /illness due to an accident? Yes_____ No _____
If yes, date of accident: _____ Yes_____ No_____
Is claim pending? Yes_____ No _____

Household Size: _____ Income:_____

(Please only include household members and dependents as claimed on taxes; family members should be counted (whether or not they contribute income.) Gross income includes wages or salary before deductions, net receipts from self-employment, public assistance such as AFDC or SSI, Social Security, Veterans benefits, pension or other retirement income, unemployment compensation, workers compensation, child support or alimony, interest income, etc.)

Name of Family Member	Relationship to Applicant	Date of Birth	Gross Income	Frequency (Month/Year)	Income Source

Williamsburg Regional Hospital Financial Assistance/Charity Form

For Internal Use Only

Patient Name _____
Acct#_____

Amount turned over to outside collection agency $_____

Amount approved by WRH for Charity $_____

Materials needed to process application:_____
_____
_____
_____
_____

Date of 1st Bill _____
Date WRH Received Application and Supporting Documents _____
Was Application received within 30 days? (Circle One) Yes or No
Extended 5 Days (Circle One) Yes or No NA Final Date _____

Approvals

Collections Staff Processing Request _____Date:_____

Collections Manager's Signature _____Date:_____

Chief Financial Officer's Signature _____Date:_____

Chief Executive Officer's Signature_____Date:_____

Date Billing Department was notified of Charity Approval _____

Date Collections was Stopped on This Account _____