Patient Account Number

NORTHSIDE HOSPITAL

Date:

RE:

Dear

Attached is an application for our Financial Assistance Program, as well as a copy of Northside's Financial Assistance Policy. Our Financial Assistance Program is based on gross household income. Gross household income includes your total income for the previous twelve (12) months, which includes, for example, all earnings/wages, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, pension or retirement income, alimony and child support.

Please send this completed application along with proof of income and all expenses to the address below.

Northside Hospital Business Office
1001 Summit Blvd NE Suite 150
Atlanta, Georgia 30319
Attention: Financial Assistance

You may also complete an online application via this link:
https://northside.patient.fae-app.com/NorthsideHospital

Thank you for your immediate attention to this matter. If you have any questions, please feel free to contact us at (404) 851-6500 between 9:00 AM and 4:00 PM, Monday through Friday.

Sincerely,

Financial Assistance Counselor
Business Office
Northside Hospital

In order to be considered for Financial Assistance, the enclosed forms must be completed and returned with all supporting documentation within 10 days of receipt. Please allow 30-60 days for processing.

NORTHSIDE HOSPITAL – FINANCIAL ASSISTANCE APPLICATION
*****ACCOUNT BALANCES GREATER THAN $5,000*****

MEDICAL RECORD/ACCOUNT NUMBER: _____

PATIENT/GUARANTOR NAME: _____ D.O.B. _____

SPOUSE/PARTNER NAME: _____ D.O.B. _____

ADDRESS: _____

PHONE: _____ ALT PH # _____

STATE OF RESIDENCY: _____

INSURANCE CARRIER: _____

FAMILY INCOME DATA:

	List Number of Family Members In House Hold:	Monthly Income Per Family Member:
Single Individual		
Husband/Partner		
Wife/Partner		
Children (under 18)		
Other Dependents		
Total:		

OTHER INCOME:

	List Monthly Income Amount
Alimony/ Child Support	
Social Security/ Pension	
Public Assist / Food Stamps	
Unemployment/Workers Comp.	
Other Sources (specify)	
Total Income	

MONTHLY EXPENSES:

	Payment Amount
Rent or Mortgage (Primary and Secondary)	
Utilities Standard Deduction (Electric, Gas, Water)	
Health Insurance/Life Insurance	
Medical Bills (Non Northside Hospital)/Pharmacy Report	
Child Care/ Adult Care	
Government Tax Payments	

The undersigned hereby acknowledges the information in this statement to be true and correct to the best of my (our) knowledge. Please note that all applications for financial assistance are subject to verification of employment, obtaining credit bureau reports, other verification process or resources which may be necessary in order to substantiate your financial status.

_____ _____

RESPONSIBLE PARTY'S SIGNATURE SPOUSE'S/PARTNER SIGNATURE

IN ORDER TO BE CONSIDERED YOUR APPLICATION MUST BE RETURNED WITHIN 10 DAYS OF RECEIPT

PLEASE NOTE THAT YOUR APPLICATION WILL NOT BE PROCESSED OR CONSIDERED WITHOUT THE FOLLOWING:

1) **PROOF OF RESIDENCY – Provide applicable proof of residency in Georgia, Alabama, Florida, North Carolina, South Carolina, or Tennessee**.

   Please provide:
   - Driver's License or other identification issued by the State of Georgia, Alabama, Florida, North Carolina, South Carolina, or Tennessee, evidencing proof of residency; or
   - Other documentation establishing residency in Georgia, Alabama, Florida, North Carolina, South Carolina, or Tennessee.

2) **PROOF OF INCOME – PLEASE BLACKEN OUT YOUR SOCIAL SECURITY NUMBER ON ANY FORMS SUBMITTED.**

   Please provide one of the following:

   - Most recent bank statements for personal and business checking and savings accounts
   - Recent pay stub(s) with validation of pay frequency
   - Current year W-2 form and/or recent year tax return
   - Written verification of wage from employer
   - Written verification from public welfare agencies or other government agencies which can attest to the Patients Gross Income status for the past 12 months
   - Social Security Award Letter
   - Verification of Pension or Retirement Income
   - Alimony and/or Child Support Court Order or Divorce Decree
   - Unemployment Income Notice
   - State separation notice and status of unemployment filing
   - Notarized Letter of Support: If the Patient has no Gross Income he or she should provide written documentation from person(s) or entities who provide him or her daily living necessities (food, shelter, clothing)
   - Patients seeking assistance due to Medical Indigency may need to submit evidence of Assets
   - Verification of student status which is defined as a copy of current class schedule, registration information and a copy of the student photo ID

IF YOU HAVE NO INCOME OR OTHER MEANS OF SUPPORT, PLEASE PROVIDE LETTER OR DOCUMENT FROM PERSON(S), OR ENTITY PROVIDING YOUR PRIMARY SOURCE OF SUPPORT FOR NECESSARY LIVING EXPENSES.

3) **COPIES OF RENT/MORTGAGE, HEALTH INSURANCE, MEDICAL BILLS/PHARMACY REPORT, AND CHILD CARE. PLEASE ATTACH PROOF/COPY OF STATEMENT FOR ALL EXPENSES LISTED ABOVE. YOUR APPLICATION WILL NOT BE CONSIDERED WITHOUT THIS DOCUMENTATION.**

DO NOT INCLUDE ANY ITEMS THAT ARE DEDUCTED FROM YOUR PAYCHECK. FOR ANY ADDITIONAL NOTES OR COMMENTS ATTACH A LETTER.