



P. O. Box 690
821 N. Cobb Street
Milledgeville, GA 31061

Dear Patient:

In keeping with the mission commitment of service to the community, Oconee Regional Medical Center offers financial assistance programs for the patients and the community according to recognized need and available resources.

Enclosed you will find a financial information form, please complete and return the form with a copy of the following (**the form cannot be considered without this information**):

- Income Tax Return for year _____
- 3 current Pay Stubs or other sources of income for **all household members (includes unemployment)**. If no income, will need a wage report from the Department of Labor.
- 3 months current bank statements
- Other _____
- College students must supply the following:
 1. Copies of grants &/or loans
 2. Living expense allotments granted by scholarships
 3. Documentation from parents if they assist with living expenses
 4. Proof of student status

The completion of this application will allow us to evaluate your need for assistance with your outstanding balance at Oconee Regional Medical Center. There are guidelines that we have to follow through the State of Georgia to be able to consider you/your family eligible for the hospital assistance.

If you have any questions or concerns in completing this information, please contact our office at 478-454-3585 Monday through Friday 8:00 am-4:30 pm.

Sincerely,

Kristie Daughtry
Patient Financial Counselor
Oconee Regional Medical Center
(478) 454-3585

Brad Blackerby
Patient Financial Counselor
Oconee Regional Medical Center
(478) 454-3585

Oconee Regional Medical Center
Indigent/Charity Care Application

PATIENT NAME _____ SS# _____ D.O.B. _____ ACCOUNT # _____

ADDRESS _____ HOME PH # _____ WORK PH # _____

Indigent Care _____ Charity: _____

HOUSEHOLD INFORMATION		INCOME INFORMATION		EXPENSE INFORMATION				
MEMBER NAME	AGE	RELATIONSHIP	INCOME SOURCE	AMOUNT	W-M-Y	CREDITOR	AMOUNT	W-M-Y

TOTAL HOUSEHOLD MEMBERS: _____ TOTAL INCOME: _____ TOTAL EXPENSES: _____
(Please calculate an annual household figure)

ASSETS			SUPPORTING DOCUMENTS			
NAME OF BANK	ACCOUNT TYPE	ACCOUNT #	BALANCE	TYPE	SOURCE	WITNESSED BY:
				Proof of Income		
				Letter of Support		
				Homeless Affidavit		

(A) _____ Support Statement: My signature will certify that I, _____ of the above referenced patient, do provide all necessary essentials for living for the patient's behalf, and have done so for a period of _____ years/months.

Signature of Patient's Supporter _____

(B) _____ Homeless Affidavit: I, _____ hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in denial of this application. I also understand that a credit report may be obtained or other such measures may be taken to verify the information herein. I fully understand that Oconee Regional Medical Center Indigency Program is a "Payor of last Resort" and hereby assign all benefits from any liability actions, personal injury claims, tort settlements, or any and all insurance benefits which may become payable for illness or injury for which St. Oconee Regional Medical Center provided care.

Signature of Patient (Guardian) _____ Date _____

Witness _____ Date _____

ADMISSION SOURCE:
 ___ Admitting
 ___ Emergency Room
 ___ Outpatient

Estimated Monthly Expenses

Name: _____

Account: _____

Please complete the following estimated monthly expense sheet & return with application & requested documentation:

Type of Account	Creditor	Est. Monthly Amount
Mortgage/Rent	_____	_____
Electric/Power	_____	_____
Water	_____	_____
Gas/Heating	_____	_____
Telephone	_____	_____
Cable/Satellite	_____	_____
Car Payment(s)	_____	_____
	_____	_____
Insurance (auto/life/house)	_____	_____
	_____	_____
Cell Phone(s)	_____	_____
Internet	_____	_____

Please list additional expenses on the back of the form. If there have been lapses in your employment, please write a statement to explain how your living expenses have been paid during the unemployment.

Make sure you sign the application & return all requested documentation.