



CRISP REGIONAL HEALTH SERVICES  
"Professionally Serving, Personally Caring"

www.crispregional.org

**CRISP REGIONAL HOSPITAL  
APPLICATION FOR FINANCIAL ASSISTANCE**

**PATIENT INFORMATION:**

|                        |                               |
|------------------------|-------------------------------|
| Name:                  | Date of Service:              |
| Address:               | Social Security Number:       |
|                        | Home Phone:                   |
| Date of Birth:         | Marital Status:               |
| Employer Name/Address: | Work Phone:                   |
| How long employed?     | Position/Title                |
| Monthly Income:        | Total # of household members: |

**MEMBERS OF HOUSEHOLD:**

| Name | Relationship | Date of Birth | Social Security # | Monthly Income |
|------|--------------|---------------|-------------------|----------------|
|      |              |               |                   |                |
|      |              |               |                   |                |
|      |              |               |                   |                |
|      |              |               |                   |                |
|      |              |               |                   |                |
|      |              |               |                   |                |
|      |              |               |                   |                |
|      |              |               |                   |                |

\*\*Please note, those covered by insurance are not eligible for Financial Assistance

I understand this application is made to allow Crisp Regional Hospital to determine my eligibility for medical financial assistance under the rules established and on file at the hospital. To my knowledge, the information provided is true. If the information I have provided proves untrue, I understand I will be permanently ineligible for assistance.

\_\_\_\_\_  
Signature of Applicant/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant/Patient Phone Number

### Tax Information

In the event that you have not filed taxes for the previous year, please fill out and sign below: (please include spouse's name if applicable)

I, \_\_\_\_\_, have not filed taxes for the year 2021. I did not file due to

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### No Income Statement

In the event that you are not currently employed, please fill out and sign below.

I, \_\_\_\_\_, have not worked in the last three months. I was last employed by

\_\_\_\_\_ (employer name) on \_\_\_\_\_ (last date of employment).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Support Document

In the event that you do not own or rent your home and are living with someone, please have them fill out the information below:

\_\_\_\_\_ (applicant name) does live with me at \_\_\_\_\_ (address).

Do you financially support the above applicant? yes / no

If so how? \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

This does not serve as proof of address, it is for income verification only.

### Required information checklist:

2021 state or federal tax return for household

Last 3 months of pay stubs for household

Proof of Medicaid application

Proof of any other income/assets (food stamps, SS benefits, unemployment) for household

Copy of Drivers license

Copy of Social Security Card

Proof of physical address

Please include proof for all sources of income for each family member. You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size.

**If you have any questions, please contact your financial counselor, Melinda Allen, at 229-276-3166. She is available Monday-Friday 8:00 to 4:00.**

**Once you have completed this application, please forward the signed and dated application with any other pertinent informational documents to:**

**Crisp Regional Hospital  
PO Box 919  
Cordele, GA. 31010**

| 2022 INDIGENT CARE SCALE |          |             |             |             |             |             |             |             |             |
|--------------------------|----------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Federal Poverty          | Discount | 1           | 2           | 3           | 4           | 5           | 6           | 7           | 8           |
| 100%                     | 100.00%  | \$13,590.00 | \$18,310.00 | \$23,030.00 | \$27,750.00 | \$32,470.00 | \$37,190.00 | \$41,910.00 | \$46,630.00 |
| 125%                     | 100.00%  | \$16,987.50 | \$22,887.50 | \$28,787.50 | \$34,687.50 | \$40,587.50 | \$46,487.50 | \$52,387.50 | \$58,287.50 |
| 140%                     | 66.26%   | \$19,026.00 | \$25,634.00 | \$32,242.00 | \$38,850.00 | \$45,458.00 | \$52,066.00 | \$58,674.00 | \$65,282.00 |
| 155%                     | 66.26%   | \$21,064.50 | \$28,380.50 | \$35,696.50 | \$43,012.50 | \$50,328.50 | \$57,644.50 | \$64,960.50 | \$72,276.50 |
| 170%                     | 66.26%   | \$23,103.00 | \$31,127.00 | \$39,151.00 | \$47,175.00 | \$55,199.00 | \$63,223.00 | \$71,247.00 | \$79,271.00 |
| 180%                     | 66.26%   | \$24,462.00 | \$32,958.00 | \$41,454.00 | \$49,950.00 | \$58,446.00 | \$66,942.00 | \$75,438.00 | \$83,934.00 |
| 200%                     | 66.26%   | \$27,180.00 | \$36,620.00 | \$46,060.00 | \$55,500.00 | \$64,940.00 | \$74,380.00 | \$83,820.00 | \$93,260.00 |
|                          |          |             |             |             |             |             |             |             |             |