CRISP REGIONAL HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION:

Name:	Date of Service:
Address:	Social Security Number:
	Home Phone:
Date of Birth:	Martial 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:
__2022 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.

2023 Financial Assistance Application

If you have any questions, please contact four 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

2023 INDIGENT CARE SCALE									
Federal Poverty	Discount	1	2	3	4	5	6	7	8
100%	100.00%	$14,580.00	$19,720.00	$24,860.00	$30,000.00	$35,140.00	$40,280.00	$45,420.00	$50,560.00
125%	100.00%	$18,225.00	$24,650.00	$31,075.00	$37,500.00	$43,925.00	$50,350.00	$56,775.00	$63,200.00
140%	68.40%	$20,412.00	$27,608.00	$34,804.00	$42,000.00	$49,196.00	$56,392.00	$63,588.00	$70,784.00
155%	68.40%	$22,599.00	$30,566.00	$38,533.00	$46,500.00	$54,467.00	$62,434.00	$70,401.00	$78,368.00
170%	68.40%	$24,786.00	$33,524.00	$42,262.00	$51,000.00	$59,738.00	$68,476.00	$77,214.00	$85,952.00
180%	68.40%	$26,244.00	$35,496.00	$44,748.00	$54,000.00	$63,252.00	$72,504.00	$81,756.00	$91,008.00
200%	68.40%	$29,160.00	$39,440.00	$49,720.00	$60,000.00	$70,280.00	$80,560.00	$90,840.00	$101,120.00