

Dekalb Regional Medical Center
Uninsured Discount Program

CONFIDENTIAL

PLEASE READ CAREFULLY!

**YOUR APPLICATION WILL NOT BE PROCESSED
WITHOUT A SIGNATURE AND THE REQUIRED
DOCUMENTS.**

**(SEE THE “REQUIRED DOCUMENTS” LIST ON
PAGE 5)**

**CONTACT A FINANCIAL COUNSELOR FOR AN
APPOINTMENT**

Lisa Brown – (256) 997-2137
Heather Christenberry – (256) 997-2308

Patient Account Number:_____ Date of Application_____

PATIENT INFORMATION

PARENT/GUARANTOR/SPOUSE

Name_____

Name_____

DOB_____

DOB_____

SSN_____

SSN_____

Address_____

Address_____

City_____

City_____

State/Zip_____

State/Zip_____

Home Phone_____

Home Phone_____

Cell_____

Cell_____

Screening Process:

Primary Language? _____

1. Do you have insurance? (Y/N)_____ If yes, verify and update information for billing. Payor_____ Policy#_____ Group_____

2. Military Background/VA Benefits? (Y/N)_____

3. Have you had insurance in the past (3) months? (Y/N)_____ If yes, complete questions 1 & 2. What type of Insurance? (i.e., Medicaid, BCBS, Tricare, County Program)_____

*Reason for termination? _____

4. Have you applied for:

~Cobra insurance coverage? (Y/N)_____ When? _____

Former POE_____

~Medicaid/ Disability? (Y/N)_____ When? _____

Caseworker? _____

*Has your living and/or income status changed since you last applied?
(Y/N)_____

5. Were you a victim of a Crime? (Y/N)_____ If yes, complete the following.
~Have you filed a Police Report? (Y/N)_____ (only 72 hours to file incident)
~Completed VOC application? (Y/N)_____

PATIENT/GUARANTOR

SPOUSE/SECOND PARENT

Employer_____

Employer_____

Address_____

Address_____

City_____

City_____

State/Zip_____

State/Zip_____

Work phone_____

Work phone_____

Length of Employment_____

Length of Employment_____

Supervisor_____

Supervisor_____

Monthly Gross Wages \$_____
(Amount Before Deductions)

Monthly Gross Wages \$_____
(Amount Before Deductions)

Other Income:(Amount Before Deductions)

Other Income:(Amount Before Deductions)

Child Support \$_____

Child Support \$_____

VA Benefits \$_____

VA Benefits \$_____

Workers' Comp \$_____

Workers' Comp \$_____

Disability/ SSI \$_____

Disability/ SSI \$_____

Unemployment \$_____

Unemployment \$_____

Other \$_____

Other \$_____

Any Other Household Income: What kind?_____

Who gets it?_____

How much? \$_____

Total Household Gross Monthly Income \$_____

RESOURCES/ ASSETS

Checking: yes__ no __ Amount \$_____ Cash on Hand \$_____

Savings: yes__ no __ Amount \$_____ CC Available Credit \$_____

CD/IRA/401K \$_____

Any other resources/ assets \$_____

Vehicle 1: Yr_____ Make _____ Model_____

Vehicle 2: Yr_____ Make_____ Model_____

Vehicle 3: Yr_____ Make_____ Model_____

Living Arrangements

Rent___ Own___ Buying___ Other (explain)_____

Landlord/ Mortgage Holder/ Other: _____

Phone Number_____ Monthly Payment \$_____

Number of Dependents (Minor Children) in Household _____

Family Size _____

MONTHLY EXPENSES

Utilities \$_____ Auto Pmt \$_____ Loan Pmts \$_____

Cell/ Pager \$_____ Auto Ins \$_____ Credit Cards(min. pmts)\$_____

Cable/ Internet \$_____ Child Support \$_____ Other \$_____

Food \$_____ Medical \$_____ Other \$_____

Total Monthly Expenses \$_____

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant _____

Financial Counselor _____

REQUIRED DOCUMENTS

The following documents must be attached to process your application:

***Proof of Income:**

1. Prior year income tax return with the W2's.
2. Last 4 paycheck stubs or letter from employer.
3. Verification of any other income or assets.
4. Last 3 months bank statements.
5. Most recent credit card statements.

***Proof of Expenses:**

1. Copy of mortgage payment or rental agreement.
2. Copies of all other monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones).
3. Other documents as requested.

***Verification of any assistance:** Government housing, Food stamps, Written statement from friends/family/organizations stating the type of assistance they offer.

***Other Documents:** Drivers License or Picture ID, Social Security Card

***If no income:** Termination letter from previous employer if no income due to recent loss of employment, Letter of Support from friends/family if no income and living in their home.

***If you have applied for disability** and you retained a representative to assist you with the disability process you will need to supply your representative's contact information and a statement from your representative with status of your case.

Remember to schedule your appointment with a Financial Counselor.

LISA BROWN 256-997-2137

HEATHER CHRISTENBERRY 256-997-2308

Appointment Date _____ Time _____

