



**BON SECOURS HEALTH SYSTEM  
FINANCIAL ASSISTANCE APPLICATION**

Date Sent \_\_\_\_\_

Facility Bellefonte Physician Services Account # \_\_\_\_\_  
 Patient Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Phone# \_\_\_\_\_  
 Patient Address \_\_\_\_\_  
 Employer \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

**Family Members** (List spouse and dependent children under 18 years, or as listed on your taxes and their date(s) of birth):

Name	Date of Birth	Name	Date of Birth
1. _____ / _____	4. _____ / _____		
2. _____ / _____	5. _____ / _____		
3. _____ / _____	6. _____ / _____		

**APPLICANTS MUST SUBMIT ALL REQUIRED DOCUMENTS IN THE SAME MAILING TO:**

*Bon Secours Financial Assistance Program  
P.O. Box 742431  
Atlanta, GA 30374-2431*

Please answer each question and provide the information requested

**UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE**

DECISIONS WILL BE RENDERED WITHIN 60 DAYS OF RECEIPT OF COMPLETED APPLICATION AND PARTICIPATION WITH OUR VENDOR

Please answer all questions listed below	If YES, please provide the following for <b><u>EACH</u></b> member of the household receiving the benefit.
Is any member of your household <b>self-employed</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	COMPLETE TAX form(s) including business taxes from the most recent tax year and latest quarterly filing listing income for quarter
Is any member of your household <b>employed</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	3 most recent pay stubs or signed letter from employer
Is any member of your household receiving <b>unemployment benefits</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Benefit letter or Unemployment printout from State website
Is any member of your household receiving <b>Social Security</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	SS benefit letter or complete bank statement if direct deposited
Does any member of your household receive a <b>Pension or Retirement</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Pension/Retirement letter or complete bank statement if direct deposited
Does any member of your household receive <b>SNAP benefits</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	SNAP Letter
Does any member of your household receive a <b>Child Support</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Court ordered document or letter from non-custodial parent
Does any member of your household own <b>rental or investment property</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Rental agreement/documentation listing income amount
Does any member of your household have <b>other sources of income</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Stocks, Bonds, CD's additional property, etc... Attach current statement(s)
Does any member of your household have a <b>checking, savings or money market account</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Attach complete copy of current 30 day statement for <u>each</u> account
<b>NO INCOME:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If your household is claiming no income you must have the person providing your food, shelter, and daily living expenses sign below and indicate which type of assistance they are providing  <i>I certify that I (name) _____ (phone number) _____ provide food, shelter, and daily living expenses for the patient listed above and/or income of \$ _____ Monthly Assistance provided: _____</i> <b>Signature</b> _____ <b>Relationship</b> _____ <b>Date</b> _____	

**Applicants on a VISA must provide a copy of all insurance, financial, and/or sponsorship information provided to obtain the VISA.**

>>>Continued<<<<

