



SPARTANBURG
Regional Healthcare System

SMC SHRC PMC UMC

APPLICATION FOR PATIENT FINANCIAL AID PROGRAM

Account Number: _____

Medical Record Number: _____

Patient Name (Last, First, Middle)	Date of Birth ____/____/____	Social Security # ____-____-____
Guarantor (if different)	Date of Birth ____/____/____	Social Security # ____-____-____
Address	City State/Zip County	Phone (____)____-____

Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, list the last date of employment: _____	Marital Status _____

Household Members and Income Information *List ALL household members*****
Also list ALL household income sources including, but not limited to: Employment, Food Stamps, Social Security, Children's SSI, Unemployment, Workers Compensation, Alimony, Child Support, Military Allotments, Pensions, Rental Property Income, etc.
Please provide copy of tax returns. Failure to supply will deny application
(If you are claimed on someone else's taxes please provide information below and copy of tax returns.)

NO INCOME INFORMATION WILL AUTOMATICALLY DENY APPLICATION

Household Member's Name	Relationship	Date of Birth	Income Type (from list above...)	Gross Monthly Income	Is Individual claimed on the Household Tax return? Y or N

Do you own a business? If yes, you will need to submit a copy of your business and personal tax return for the most recent filing year.
 Yes No (please include copies of Schedule C and/or K)

Housing/Real Estate/Other Property Information			
Own:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mortgage Payment:	\$ _____
Rent:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Rent:	\$ _____

By signing, I certify that the information given in this application is true and complete to the best of my knowledge; and I hereby authorize the release of any information required to determine my eligibility for the SRHS Patient Financial Aid Program. I understand that this application covers only services provided by Spartanburg Regional Healthcare System. This does not include services provided by others who may have assisted with my care. Should this application be approved and it is determined that there is a payer source for my services; hospital charity will only cover the remaining balance after payment from the payer source.

Applicant's Signature: _____	Date: _____	Time: _____
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It will be the patient's responsibility to follow up on the status of the financial aid application.

For consideration for SRHS financial aid, please complete all sections of this application and mail to:

SRHS Patient Financial Aid Program
Patient Financial Services
101 East Wood Street
Spartanburg, SC 29303

If you need assistance please call Customer Services at 864-560-4123