



Tuomey Healthcare System
129 North Washington St.
Sumter, SC 29150
(803) 774-9000

The following documents and information are required in order to complete your Tuomey Healthcare System Financial Assistance application. In an effort to better serve you, we request that you provide all identified information with the submission of your application. Incomplete applications will not be processed.

- 1) Proof of Employment for the past 6 weeks
- 2) Proof of household income including anyone living in the household
- 3) Proof of unemployment compensation, i.e. letter of approval, copy of unemployment print out
- 4) Proof of any state assistance that may be received in the household, i.e. food stamps, Medicaid for the past 6 weeks
- 5) Proof of application for state assistance and/or denial if not approved
- 6) Complete copy of most recent yearly tax returns
- 7) Copy of bank statement for the past 6 weeks
- 8) Notarized statement of support if unemployed
- 9) Notarized income statement from employer if no bank account or check stubs are available
- 10) Any other documentation requested in order to process your application

We thank you for choosing Tuomey Healthcare System for your healthcare needs. Your application will be processed upon receipt with all pertinent documentation. Please be advised that applications that are received incomplete or with missing documentation/information will be held open for 10 days. If requested information is not received within 10 days of notification, your application will not be processed.

Application Date:		
Patient MR #:		Patient Account #: Date of Service:
Patient Name:		Social Security #:
Date of Birth:		Marital Status:
Address:		City, State, Zip Code:
Telephone #:		Secondary Contact Telephone #:
Employee Name:	Telephone #:	Job Title:
Address:	City, State, Zip Code:	Supervisor:
Additional Employer:	Telephone #:	Job Title:
Address:	City, State, Zip Code:	Supervisor:

Only complete if unemployed

Date of Unemployment:	Collecting Unemployment: <input type="checkbox"/> Yes <input type="checkbox"/> No
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# of Household Members:			
Name:	Relationship	Age:	Occupation:
Name:	Relationship:	Age:	Occupation:
Name:	Relationship:	Age:	Occupation:
Name:	Relationship:	Age:	Occupation:

Important: To be considered for Financial Assistance for medically necessary services, this confidential application must be completed. For it to be considered complete, you must answer all questions, sign and date the form, and attach all required documentation:



Acct: **Unit:**
 ' / **DOS:** //
Admit Age: **DOB:** //

Statement of Financial Condition



FAS001 Rev. 11/01/2011

Current Monthly Financial Information

Patient

Spouse

Current Household Income	\$	\$
Income from Business/Self Employment	\$	\$
Other Income received, i.e. real estate, dividends, Social Security benefits payment, alimony/child support, unemployment	\$	\$
Total Income:	\$	\$

Household Expenses:	<input type="checkbox"/> Rent <input type="checkbox"/> Own	\$	\$
Automobiles:	<input type="checkbox"/> Lease <input type="checkbox"/> Finance <input type="checkbox"/> Own	\$	\$
Electric		\$	\$
Telephone		\$	\$
Water		\$	\$
Miscellaneous – Please list bills and amounts		\$	\$

Household Income less Household Expenses

Total Household Income:	\$	\$
Total Household Expenses:	\$	\$
Total Balance Remaining After Expenses	\$	\$

I have applied for <input type="checkbox"/> Medicaid <input type="checkbox"/> Social Security <input type="checkbox"/> Disability	Date of Application:
Status of Application: <input type="checkbox"/> Pending <input type="checkbox"/> Approved <input type="checkbox"/> Denied	

By way of my signature on this application, I hereby acknowledge and provide permission for Tuomey Healthcare System to complete a verification of employment and credit check for the purpose of determining my eligibility for financial assistance and/ or a financial discount. I understand and acknowledge that I will be required to provide documentation/ information as verification of the statements of my application.

Patient Signature

Date

Spouse/Guarantor Signature

Date

Statement of Financial Condition

FAS001 06/01/2011

Acct:

Unit:

DOS: //
DOB: //