Financial Assistance Program

Newberry County Memorial Hospital assists patients in obtaining payment from third parties such as Medicaid and Medicare. If you are eligible for Medicaid, and you are not currently signed up, we can help you apply. We also offer financial assistance for healthcare services to persons who qualify. This form must be completed and signed by you. We use income guidelines established by the U.S. Dept. of Health and Human Services to determine if you are eligible for financial assistance. We do verify assets regarding your eligibility.

Required Documents

Newberry County Memorial Hospital (NCMH) Financial Assistance is subject to, and will be reversed if the applicant fails to first apply for all other available financial benefits including Public Aid Benefits. The following documentation must be attached to the fully completed and signed NCMH Financial Assistance application.

Please provide all the information promptly so we may try to help you as quickly as possible.

Applicants currently receiving SNAP benefits **may** qualify for financial assistance with:

- A fully completed Newberry Hospital financial assistance application
- A copy of your Household Summary print out available at DSS
- Picture ID

All other applicants please provide the following:

- Picture ID
- Most recent tax return
- Proof of gross wages for the last 30 days
- Most recent bank statement
- Proof of all income benefits you are receiving, including pension, social security, unemployment, disability, as well as, child support, alimony
- If you are unemployed with no source of income, a statement explaining how you pay for your basic living expenses

If you have any questions, please contact our patient support representatives at (803)405-7178 or (803)405-7450. You may also mail your application to NCMH c/o RCA Financial Assistance Office, P.O. Box 497, Newberry, SC 29108.

NCMH Financial Assistance Office Use Only

Date Rec'd:_____

Account #'s:

_____

Total Balance Due: $_____

□ Approved: _____

□ Denied for the following reasons:

_____

_____

Signature: _____ Title: _____ Date: _____ Time: _____

Newberry County Memorial Hospital Financial Assistance Program Application Form

Please complete this worksheet and return to the RCA/Financial Assistance office. Please print.

Have you recently applied for Disability or Medicaid? □ Yes □ No If Yes, please see RCA/Financial Assistance when submitting this application.

1. Patient Information:

Name _____ Birthdate _____ Social Security Number _____ Marital Status: □Single □Married □Widowed □Separated □Divorced

Address _____ City _____ State _____ Zip Code _____ Phone #_____

Employer _____ $_____ Gross Annual Salary

2. Spouse Information: ***If the Patient is married, this section must be completed.***

Name _____ Birthdate _____ Social Security Number _____ Marital Status: □Single □Married □Widowed □Separated □Divorced

Address _____ City _____ State _____ Zip Code _____ Phone #_____

Employer _____ $_____ Gross Annual Salary

3. Dependents: (The # of persons the applicant may claim as a personal exemption on the applicant's Federal Income Tax Return.)

Total Number of Dependents: _____

1. _____ Dependent's Full Name and Date of Birth
2. _____ Dependent's Full Name and Date of Birth
3. _____ Dependent's Full Name and Date of Birth
4. _____ Dependent's Full Name and Date of Birth

4. Assets: Checking/Accounts: _____ Name and Address of Institution Account Balance & Date: _____

Savings/Money Market/CD Accounts: _____ Name and Address of Institution Account Balance & Date: _____

All Vehicles Owned by Model and Year:
1. _____ Tax Assessed Value: $_____
2. _____ Tax Assessed Value: $_____
3. _____ Tax Assessed Value: $_____
4. _____ Tax Assessed Value: $_____

5. Other Monthly Income: Total Other Monthly Income: $_____

Do you receive SNAP benefits / Food Stamp benefits? Yes / No

SS/SSI $_____ Alimony/Foster Care/Child Support: $_____ Pension: $_____ other: $_____

I certify that everything stated in this application and on any attachment is correct. By signing below, I authorize you to verify all information submitted. I agree to immediately supplement my application with any changed financial circumstances. I understand that I cannot apply for financial assistance and financial assistance may be reversed, if I have a pending liability claim, workers comp claim, insurance claim, or my worksheet contains false or incomplete financial information.

Signature: _____ Date: _____ Time: _____