
315 West Hickory Street
Sylacauga, AL 35150

Dear Patient/Guarantor:

You have indicated that you need assistance with your hospital bill. In order for us to evaluate your financial situation, the following documents are required:

- A completed **Financial Needs Assessment Form** (attached)
- Proof of Income:
  - A copy of your most current Federal tax form(s) with ALL schedules, including W-2(s), 1099, 1040
    - If these forms are not available an IRS letter of non-filing is required (1.800.829.1040)
  - A copy of your most recent three (3) paycheck stubs for you and anyone working within your household
  - Proof of Unemployment and/or Pension, Alimony, Child Support, as applicable
  - Proof of Social Security Income if applicable
- A copy of your most recent three (3) bank statements for each account that you have
- Letter from physician, if unable to work due to illness confirming your inability to work
- Letter if you are being supported by relatives/friends or are unemployed
- Verification letter if receiving Food Stamps
- Verification of Affordable Care Act approval or denial with or without subsidies
- A list of your outstanding medical debts and monthly pharmacy costs
- Your Medicaid number, or letter stating you are not eligible for benefits, if applicable
- Your Medicare disability application letter, or letter from attorney handling your case, if applicable
- Other: _____

If you have questions, please contact one of our Financial Counselor's at (256) 401-4017 or (256) 401-4018. **Please be advised that we will continue our normal billing practice until the information is received and processed.**

Financial Assistance applicants must comply with screening and application requirements for public assistance (for example Medicaid) in order to be eligible for Financial Assistance.
All documentation should be returned to:

Coosa Valley Medical Center
Financial Counselor
315 West Hickory Street
Sylacauga, AL 35150

Sincerely,

Patient Financial Services

COOSA VALLEY MEDICAL CENTER

# FINANCIAL NEEDS ASSESSMENT FORM

| *MR Number & Account Number to be completed by hospital personnel* | *MR Number:* | *Account Number:* | *Additional Account Number:* |
|---|---|---|---|

Please provide the following information completely and accurately. Information is subject to verification.
Please attach a list of additional household members if there are more than five (5) members.

| Patient's Name (First, MI, Last): | Social Security Number: | Date of Birth |
|---|---|---|
| Address: | Telephone Numbers:<br>Home/Cell: ( ) Work: ( ) | |
| City/ST/Zip: | Responsible Party Name (First, MI, Last): | |
| County: | Total # Household Members you claim as a tax dependent | |

| ***List ALL household member names*** | **Disabled?** | **Age/Date of Birth** | **Relationship to patient** | **Monthly Income** |
|---|---|---|---|---|
| **1.** | | | | **$** |
| **2.** | | | | **$** |
| **3.** | | | | **$** |
| **4.** | | | | **$** |
| **5.** | | | | **$** |

| **Monthly Income** | | **Monthly Expenses** | |
|---|---|---|---|
| Responsible Party's Gross Income (before taxes) Employer: | **$** | Rent/Mortgage/Homeowner's Insurance | **$** |
| Other Household Gross Income (before taxes) Employer: | **$** | Utilities (Electricity/ Water/Gas/Cable) | **$** |
| Investment Income (Annuities/Stocks/Dividends) | **$** | Telephone | **$** |
| Child Support/Alimony Received | **$** | Child Support/Alimony Paid | **$** |
| Rental Property Income | **$** | Food (excluding cigarettes & alcoholic beverages) | **$** |
| Pension/Retirement/Unemployment | **$** | Car Payment (loan + insurance) Model and Year of Car | **$** |
| Social Security Benefits | **$** | Child Care | **$** |
| VA Benefits | **$** | Medical & Pharmacy Bills | **$** |
| **Total Monthly Income (before taxes)** | **$** | **Total Monthly Expenses** | **$** |
| **Assets** | | **Liabilities** | |
| Value of Residence(s) | **$** | Residence Loan Balance/Mortgage | **$** |
| Checking Account Balance | **$** | Balance Owed on Credit Cards | **$** |
| Savings/Money Market/CD's/Retirement Funds | **$** | Auto Loan Balance | **$** |
| Value-Auto/Boat/Motorcycle/Recreational Model/Year | **$** | Total Medical Bills (attach list) | **$** |
| Other: | **$** | Real Estate Taxes | **$** |
| **Total Value of Assets** | **$** | **Total Liabilities** | **$** |

Other Coverage:

- Are you seeking Financial Assistance because of a work-related accident or injury?
- Are you seeking Financial Assistance because of a motor vehicle accident?
- Do you have a lawsuit or other insurance claim pending for coverage of this illness or injury?

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through Coosa Valley Medical Center. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by Coosa Valley Medical Center to obtain such assistance and will assign to Coosa Valley Medical Center, and upon receipt will pay to Coosa Valley Medical Center, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Coosa Valley Medical Center will result in the denial of this application. I also authorize Coosa Valley Medical Center to check my credit history through the credit bureau, if deemed appropriate.

_____ _____

Signature of Patient (Responsible Party) Date