SPARTANBURG
Regional Healthcare System

FINANCIAL ASSISTANCE APPLICATION

Account Number: Medical Record Number:

Patient Name (Last, First, Middle)	Date of Birth / /	Social Security # _____-_____-_____
Guarantor (The individual responsible for payment of services received.)	Date of Birth / /	Social Security # _____-_____-_____
Address City State/Zip County		Phone (_____)_____-_____

Are you employed? ☐Yes ☐No	US Citizen ☐Yes ☐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 all income documentation. Incomplete applications will be denied.

(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 Source (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:	☐ Yes	☐ No	Mortgage Payment:	$_____
Rent:	☐ Yes	☐ 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 Assistance 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 the patient's 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:

It will be the patient's responsibility to follow up on the status of the financial assistance application.

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

SRHS Patient Financial Assistance Program
Patient Financial Services
PO Box 27069
Greenville, SC 29616-2069

If you have questions or need help completing the form, call Customer Service at 864-596-1001 or 800-281-5346.