LEXINGTON MEDICAL CENTER

2720 Sunset Boulevard, West Columbia, South Carolina, 29169 • (803) 791-2000

FINANCIAL ASSISTANCE PROGRAM

Section 1. Applicant Information

Name (First, Mlddle, Last):_____

Date of Birth:_____ Social Security #:_____

Address:_____

City: _____ State: _____ Zip Code: _____ Phone Number:_____

☐ Own ☐ Rent ☐ Homeless ☐ Housing provided by relative or friend

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Seperated

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Disabled ☐ Student

Employer:_____

If unemployed, last date worked:_____

Section 2. Household Members as claimed on tax return (Use separate page for additional dependents.)

Name	Social Security #	Relationship	Date of Birth

Section 3. Third Party Information

1. Is Illness due to a motor vehicle or personal injury accident? ☐ Yes ☐ No ☐ Not Applicable

   Date of Accident: _____

2. Do you receive or have you applied for Medicaid? ☐ Yes ☐ No ☐ Not Applicable

3. Have you applied for insurance through the Healthcare Market Exchange? ☐ Yes ☐ No ☐ Not Applicable

CONTINUED ON NEXT PAGE

Section 4. Income (Provide income information for yourself, your spouse and all other family members(if applicable).

Income Source	Monthly Gross Pay	How Often	Who Receives This Income
Wages/Self-Employment			
Social Security Benefits			
Pension/Retirement/Annuity			
Child Support			
Unemployment, Short/Long-Term Disability Benefits			
Workers' Compensation			
Interest/Dividends/Investment			
Rental Property Income			

1. Do you or other household members own real property excluding your primary residence? (Real Estate, Land, Investment Property, Life Estates, Mobile Homes, etc.) ☐ Yes ☐ No
   (Use separate page for additional properties.)

Type of Property	Owner (if jointly owned, list all)	Market Value

CONTINUED ON NEXT PAGE

Section 5. Liquid Assets and Lump Sum Payments (Provide Checking Account, Savings Account, Saving Certificate, Stocks or Bonds, Trust Accounts.) (Use separate page for additional accounts.)

☐ **I do not have a checking, savings, money market or other liquid asset account(s).**

Account Type/ Number	Account Owner	Bank/Facility Name	Balance

Lump Sum Payment Income Source	Has any household member received the following:	If yes, when was this payment received?	Household Member
Inheritances	☐ Yes ☐ No		
Lottery or Other Winnings	☐ Yes ☐ No		
Insurance/Worker's Comp Settlement	☐ Yes ☐ No		
Social Security/VA Disability Settlement	☐ Yes ☐ No		
Severance Pay	☐ Yes ☐ No		
Capital Gains	☐ Yes ☐ No		
Other Lump Sum Payment	☐ Yes ☐ No		

*The liquid asset and lump sum payment information is required to process your application.

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Please note, failure to complete <u>all</u> sections may result in a denied application.

☐ I understand that this application applies only to services provided by Lexington Medical Center and Affiliated Physician Practices. This does not apply to services provided by others who may have assisted in my treatment. **I understand that not all medical services at Lexington Medical Center and Affiliated Physician Practices qualify for financial assistance to include treatment for all elective procedures and all treatment related to a motor vehicle accident.**

☐ I understand that my case record is confidential, and no information will be released from it unless properly authorized by me.

I authorize Lexington Medical Center to obtain a copy of my credit report. This information will be used to determine my eligibility status for this program. I also under that Equifax Information Services(credit report agency) forbids Lexington Medical Center and Affiliated Physician Practices from giving this information to consumer for personal use of knowledge.

I attest that I have read or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or withheld any information regarding any situation, I am liable for prosecution for fraud and Lexington Medical Center and Affiliated Physician Practices reserve the right to reverse my approval for financial assistance. I authorize the release of any information needed to determine my eligibility for the Lexington Medical Center Financial Assistance Program.

Applicant's Signature		Date
Signature of Authorized Representative (if applicable)	Relationship	Date

FOR OFFICE USE ONLY		
Patient Name	Birth Date	MRN