STEPHENS COUNTY HOSPITAL
163 HOSPITAL DRIVE
TOCCOA, GA 30577
706-282-4284 / 706-282-4343 / 706-282-4167 FAX 706-282-4327

OFFICE USE ONLY
(PLEASE DO NOT WRITE IN THE AREA BELOW)

APPLICATION FOR FREE OR REDUCED CHARGES

PATIENT INFORMATION

NAME:_____

ADDRESS:_____

CITY:_____ **COUNTY:**_____

PHONE #:_____ **CELL:**_____

PERSON COMPLETING APPLICATION, IF OTHER THAN PATIENT

NAME:_____

ADDRESS:_____

PHONE #:_____ **RELATIONSHIP:**_____

LIST THE MEMBERS OF THE PATIENTS HOUSEHOLD, THEIR RELATIONSHIP TO THE PATIENT AND EACH PERSON'S INCOME. PLEASE LIST IF THIS INCOME IS WEEKLY, MONTHLY OR ANNUALLY.

NAME	BIRTHDATE	RELATION	WEEKLY INCOME	MONTHLY INCOME	ANNUAL INCOME

IF **YOU HAVE A BROTHER OR SISTER (EXTENDED FAMILY) WHO LIVES WITH YOU, IS NOT YOUR LEGAL GUARDIAN AND IS NOT RESPONSIBLE FOR PAYING YOUR MEDICAL BILLS, YOU DO NOT COUNT THEIR INCOME, NOR DO THEY COUNT ON THE HOUSEHOLD TOTAL INCOME**

BY SIGNING BELOW, I VERIFY THAT ALL INFORMATION IS CORRECT AND COMPLETE.

SIGNATURE OF APPLICANT_____**DATE**_____

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HOSPITAL STAFF USE (10/09)

 # IN HOUSEHOLD_____**TOTAL INCOME**_____**INCOME VERIFIED YES NO**
SENT FOR PROOF OF INCOME_____**DATE**_____
(AVERAGE MONTHLY INCOME FOR THE LAST YEAR OR LAST THREE MONTHS, WHICHEVER IS MORE FAVORABLE.)
ELIGIBILITY - FREE SERVICE _____**DISCOUNT**_____**PENDING**_____
INELIGIBLE_____**REASON**_____

HOSPITAL STAFF SIGNATURE_____**DATE**_____