AnMed Health Cannon

Financial Assistance Application

Full Name:		ACCT#:	DOB:
Address:			SSN: - -
Home Phone: ( )- -	Mobile Phone: ( )- -	County:	Marital Status:
Email Address:			
Legal resident/citizen: Yes or No	Place of Birth:		Lived in US Since:
Emergency Contact:			Phone: ( )- -
Health Insurance Company Name:			
Policy Holder Name:		Policy #	
Group #:		Effective date:	

List All Household Members :

Name	Date of Birth	SSN	Relation to Patient	Sex/Race
		- -		/
		- -		/
		- -		/
		- -		/
		- -		/
		- -		/

Current Employment:	Pay Rate $ Hrs/wk
Job Title:	Date of Employment:
Phone: ( )- -	
Past Employment:	Job Title:

COBRA: Has a member of the household lost their job within the past 60 days ☐Yes ☐No

Did he/she receive a COBRA election notice? ☐Yes ☐No

Did he/she elect COBRA coverage? ☐Yes ☐No

If he/she did not elect COBRA coverage, please check one: ☐premium too expensive ☐new coverage

Gross Income	Patient Income	Spouse Income
Wages	$	$
Pension/Retirement	$	$
Social Security Retirement	$	$
Social Security Disability/SSI	$	$
Veterans Benefits	$	$
Unemployment	$	$
Child Support	$	$
Housing/Utility Assist.	$	$
Food Stamps	$	$
Alimony	$	$
Other Income	$	$

Property you own	Tax Value	Loan	Mortgage Company
	$	$	$
	$	$	$

OTHER:

Year/Make/Model of Any Vehicles/Boats/Motorcycles/Trailers/RV	Tax Value	Loan	Bank/Lender
	$	$	
	$	$	
	$	$	
	$	$	
	$	$	
	$	$	

Accounts	Amount	Institution and Location	Account #	Joint w/	Individual?
Checking	$				
Checking	$				
Savings	$				
Savings	$				
CDs	$				
Stocks /Bonds	$				
IRA / 401K	$				

I hereby certify that the information provided in this Patient Financial Statement is true, accurate and complete to the best of my knowledge. I hereby authorize the Hospital to contact any person, firm or organization to verify any of the information given and I hereby authorize any such person, firm or organization to release to the Hospital any financial information it may request. The hospital has provided information to me regarding insurance options available. If the hospital believes that I may be eligible for coverage such as Medicaid, I agree to cooperate with the facility's efforts in obtaining benefits.

Signatures	Date	Witness
Patient/Parent: X		
Patient's Rep:		

NOTES: Parent should sign for a minor child.

Other information you would like to provide:

Mail Completed Application to:
AnMed Health Cannon
Attention Financial Counselor
PO Box 188
Pickens, SC 29671