EMORY
HEALTHCARE

FINANCIAL STATEMENT PROFILE

Name:_____ SS#:_____

Street Address:_____

City:_____ State:_____ Zip:_____ Contact Phone#:_____

Employer:_____ Years Employed:_____

Are you married? ___ Yes ___ No Spouse's Name:_____

Number of Dependents *(include yourself):*_____ Ages:_____

Number of Household members:_____

PATIENT'S INCOME INFORMATION

Salary: $_____

Is this amount:___ Hourly ___ Monthly ___Yearly

Unemployment: $_____

Social Security or Disability: $_____

AFDC: $_____ Child Support: $_____

Savings Account: $_____

Checking Account: $_____

Other: $_____

SPOUSE/OTHER HOUSEHOLD MEMBER'S INCOME INFORMATION

Salary: $_____

Is this amount:___ Hourly ___ Monthly ___Yearly

Unemployment: $_____

Social Security or Disability: $_____

AFDC: $_____Child Support: $_____

Savings Account: $_____

Checking Account: $_____

Other: $_____

Please check below the services that you <u>received</u> from Emory

___ Emory University Hospital/Emory University Orthopaedics and Spine/ Emory Rehabilitation Hospital/Emory University Hospital Midtown, Emory University Hospital Smyrna/Emory Saint Joseph's Hospital of Atlanta/Emory Johns Creek Hospital

___ The Emory Clinics/Emory Specialty Associates

___ Emory Decatur Hospital/Emory Hillandale Hospital/Emory Long Term Acute Care

PLEASE SUBMIT THE FOLLOWING DOCUMENTS (as applicable) WITH THIS FORM:

___ Last Two Pay Stubs

___ All Bank Statements for the previous two months

___ Last year Tax Return

___ Income Award Letter

___ Proof of Georgia Residency Documents*

*At least one of the following documents: Utility bill(s), driver's license, or State of Georgia ID card.

THE PRECEDING INFORMATION IS TRUE AND CORRECT:

Signature: _____ Date:_____

At any time during the application process, Emory may request additional documentation, such as Medicaid Denial Letter, to assist the determination of your eligibility for Financial Assistance. Should your financial situation change, Emory may request a new application. A determination of eligibility for financial assistance will be effective for a maximum of 12 months. A new application is needed for the re-determination of your eligibility of Financial Assistance after the maximum 12 months approval period.

Any misrepresentation of the above information may result in the retroactive denial or reduction of financial assistance and the patient/guarantor being held liable. In addition, Emory Healthcare reserves the right to evaluate a patient's eligibility under the Emory Healthcare Financial Assistance Policy from time to time and to adjust the patient's account as necessary.