LEXINGTON MEDICAL CENTER

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

Financial Assistance Program

Date:_____

Patient Name:_____

Patient Address 1:_____

Patient Address 2:_____

Account Number:_____

Dear _____,

As your Financial Counseling team at Lexington Medical Center, we would like to take the opportunity to inform you about our Financial Assistance Program. This program is designed to provide financial assistance to patients who are experiencing financial hardships and are unable to pay their hospital bills. The documents listed below are necessary to determine eligibility for assistance.

- ☐ Completed Financial Assistance Application
- ☐ Photo ID and Social Security Numbers for eligible household members
- ☐ Income Verification (☐ Four (4) Pay Stubs - Bi-Weekly; ☐ Eight (8) Pay Stubs –Weekly; ☐ Other)
- ☐ Income Information Form (attached)
- ☐ Complete bank statements for all applicable checking and saving accounts.
  All pages are required for a 30 day statement.
- ☐ Rent Receipt or Current Lease
- ☐ Proof of Marital Separation (attached)
- ☐ Food and Shelter Form (attached)
- ☐ Proof of Food and / or Housing Assistance (I.E. SNAP, WIC, Section 8 Housing)
- ☐ Financial Support Form (attached)
- ☐ Other (attached)

This information can be brought to the Financial Counseling Office located at Lexington Medical Center. For your convenience, you may also return the documents in the postage-paid return envelope that is provided. Please return this information immediately, without the supporting documentation we cannot consider you for our programs. If you have any questions, please contact our office and we will be happy to assist you.

Thank you for allowing us to service your healthcare needs.

_____

Financial Counseling Department
(803) 791-2490

LEXINGTON MEDICAL CENTER

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FINANCIAL ASSISTANCE PROGRAM

I. Applicant – Identifying Information

Name: _____

Date of Birth: _____ Social Security #: _____ Marital Status: _____

Mailing Address or current address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Telephone numbers: (H) _____ (W) _____ (C) _____

What are your current living arrangements? ☐ Own ☐ Rent ☐ Homeless ☐ Housing provided by relative or friend

II. Third Party Information

1. Is there any other insurance? ☐ Yes ☐ No What type: _____
2. Is illness due to an accident? ☐ Yes ☐ No What type: _____

   Date of Accident: _____ Is claim pending? ☐ Yes ☐ No
3. Do you receive or have you applied for Medicaid? ☐ Yes ☐ No

   Date applied: _____ If approved, Medicaid ID Number: _____

   What was the reason for denial? _____
4. Have you applied for insurance through the Healthcare Market Exchange? ☐ Yes ☐ No

   Date applied: _____ What was the outcome: _____

III. Household Members or Dependents

Name	Social Security #	Relationship	Date of Birth	Marital Status

IV. Income

1. List the amount of monthly income from all sources. (Income includes gross wages or salary, net receipts from self-employment, regular public assistance payments such as AFDC or SSI, Social Security, Veteran's Benefits, pension or other retirement income, unemployment compensation, worker's compensation, child support or alimony, interest income, etc.)

Name of Household Member	Gross Income	Frequency	Name & Address of Source

2. If no one is employed, how are you being supported? Please explain: _____

_____

_____

3. Have you or anyone in the household received a lump sum of money in the past 3 months (from tax refund, insurance settlement, etc)? ☐ Yes ☐ No

   If yes, amount received: _____ From Whom? _____

V. Resources

1. Do you or other household members own real property excluding your primary residence (second home, land, investment property, life estates, mobile homes, etc)? ☐ Yes ☐ No

   If yes, give the following information:

Type	Owner(s) (if jointly owned, list all owners)	Location	Market Value

2. Do you or other household members own taxable recreational property excluding your primary residence (Motorhome, motorcycles, or other kinds of vehicles)? ☐ Yes ☐ No

   If yes, give the following information:

Type	Registered Owner(s)	Year, Make & Model	Market Value

3. Do you or other household members own liquid assets (cash on hand, check or saving accounts, savings certificates, stocks or bonds, trust accounts)? ☐ Yes ☐ No

If yes, give the following information:

Type	Name on Accounts	Company Name	Account Number	Amount/Value

VII. Statement of Understanding

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 understand that Equifax Information Services (credit report agency) forbids LMC from giving this information to consumer for personal use of knowledge.

I certify 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 have withheld any information regarding any situation, I am liable for prosecution for fraud. I authorize the release of any information needed to determine my eligibility for the LMC Financial Assistance Program.

<table>
<tr><td colspan="3">Applicant's Signature</td><td>Date</td></tr>
<tr><td colspan="2">Signature of Authorized Representative/ Relationship</td><td>Address</td><td>Date</td></tr>
<tr><td>Witness Signature</td><td>Date</td><td>Approving Designee Signature</td><td>Date</td></tr>
<tr><td>Interviewer</td><td>Date</td><td colspan="2">Company Interviewed</td></tr>
</table>

LEXINGTON MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM WORKSHEET (FOR OFFICE USE ONLY)

VIII. Case Notes

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