Ballad Health Application for Financial Assistance

Application Date:		_Patient's Name:				
Last F	our of Social Security #:	_DOB:	Guarantor #:			
Αссοι	unt Number(s),		.			
Pleas belov	e provide all documentation listed v. Documentation should include a	below that applies. Sign and a light sign and the high sign and th	nd return to the address listed ousehold.			
Requi	ired Documentation (*Do not send	originals * Please use black	k ink)			
	Last two years of Federal Tax Returns ar form from the IRS.	re required. If you did not file tax	xes, you must provide a 4506-T			
	W-2 and last 3 pay stubs.					
	If you are drawing Social Security, Disabi	lity, or a Military Pension, you w	ill need to provide the benefit letter.			
	Retirement income, pension, annuity, sh	nort/long term disability, or wor	ker's compensation.			
	If you receive Food Stamps, please prov	ide a copy of the approval letter.				
	Stocks, Bonds, CD's and Mutual Funds					
	If you own your home, you must provi	ide copies of your most recent	mortgage statement.			
	Provide the most recent copy of your ch statements.	ecking, savings, and Health Savir	ngs Account. Include all pages of the			
	Medicaid approval or denial letter.					

Determining Eligibility

Ballad Health will determine financial assistance eligibility based on Federal Poverty Income Guidelines and assets.

Continued Collections During Your Application Process

Please note that collection actions on your account will be suspended during the consideration of a completed charity application. You will have 30 days from the date of the financial application to provide all supporting documentation or your account.

If you need assistance in completing this application, please visit a Ballad Health facility, or call 888-288-5174 Monday – Friday, 8:00 a.m. to 4:30 p.m.

Mailing Address:

Ballad Health Po Box 746465 Atlanta, Ga 30374



Patient Full Name		Date of Birth		R	Responsible Party (Spouse/Guardian/Guarantor) City				
Address (Physical Address)	Zip Code	7 in Code							
Last four of social security nun	nber	Home Telephor	ne No.	Marrie	d ()	Single ()	Separate	ed ()	Divorced ()
Homeowner ()	Rent ()	1	Month	ly Payment		Approxi	mate Value \$		
Employer (Name & Address	s) q Unemployed	Tel.#	 	Emp. Since		Mo	onthly Income	2	
Are any of the accounts listed of	lue to a motor vehicle	accident or any other	personal in	njury? Yes	() No (()			
If yes, please provide the follow Policy Number:	-			ey Name		Ph	one Number:		
Spouse Information									
Name:		Social Security	y No.						
Employer (Name and Address)			Tel.#	, ,	Emp.	Since	M	onthly In	come
Dependents									
Name	Date of Birth	Relationship		Name	e	D	ate of Birth	Re	elationship
Monthly Expenses		M	onthly Inc	ome		Г		Assets	
Mortgage/Rent \$	<u> </u>	Patient	ontiny me	\$			Checking Account		\$
Electric \$		Spouse		\$			Savings Acc		\$
Water \$ Telephone/Cell \$		Social Secur	rity	\$	_		Health Saving		
Food \$		Disability Unemploym	ant	\$		-	Certificates of Property	n Deposit	\$
Clothing \$		Child Suppo		\$		-	Other		\$
Auto payment(s) \$		Alimony	11	\$			Other		Ψ
Child Care \$		Food Stamps	2	\$					
		Worker's Con		\$		_			
		Dividends, I	nterest	\$			Additional A	Assets	Estimated Valu
		Other Incom	ie	\$			Auto #1		\$
						_	Auto #2	// 1	\$
						-	Motorcycle Motorcycle		\$
						-	Boat	#2	\$
tal Number in Household:						-	Recreational	Vehicle	\$
		Total Incon	ne	\$					
icant's statement: I do hereby certify this application. I also understand the ent/guardian/guarantor has the abil	nat Ballad Health has the lity to pay for their ser	e right to reverse its decisi vices. I am giving Ballad I	on concerni Health perm	ng charity dis	counts whe	en discovery dit file and	of information	is made tl	hat indicates th
e companies contracted by Ballad He	calcin for the purpose of								
					— Da	ate			