



Financial Assistance Program

Newberry Health assists patients in obtaining payment from third parties such as Medicaid and Medicare. If you are eligible for Medicaid, and you are not currently signed up, we can help you apply. We also offer financial assistance for healthcare services to persons who qualify. This form must be completed and signed by you. We use income guidelines established by the U.S. Dept. of Health and Human Services to determine if you are eligible for financial assistance. We do verify assets regarding your eligibility.

Required Documents

Newberry Health Financial Assistance is subject to and will be reversed if the applicant fails to first apply for all other available financial benefits including Public Aid Benefits. The following documentation must be attached to the fully completed and signed Newberry Health Financial Assistance application.

Please provide all the information promptly so we may try to help you as quickly as possible.

Applicants currently receiving SNAP benefits qualify for financial assistance with:

- A fully completed Newberry Health financial assistance application
- A copy of your Household Summary print out available at DSS
- Picture ID

All other applicants please provide the following:

- Picture ID
- Most recent tax return
- Proof of gross wages for the last 30 days
- Most recent bank statement
- Proof of all income benefits you are receiving, including pension, social security, unemployment, disability, as well as, child support, alimony
- If you are unemployed with no source of income, a statement explaining how you pay for your basic living expenses

If you have any questions, please contact our patient support representatives at (803)405-7669. You may also mail your application to Newberry Health c/o Financial Assistance Office, P.O. Box 497, Newberry, SC 29108.

Newberry Health Financial Assistance Office Use Only

Date Rec'd: _____

Account #'s: _____

Total Balance Due: \$ _____

Approved: _____

Denied for the following reasons: _____

Signature: _____ Title: _____ Date: _____

Newberry Health Financial Assistance Program Application Form

Please complete this worksheet and return to the Financial Assistance office. Please print.

Have you recently applied for Disability or Medicaid? Yes No If Yes, please see Financial Assistance when submitting this application.

1. Patient Information:

_____ Marital Status: Single Married Widowed
 Name Birthdate Social Security Number Separated Divorced
 _____ Phone # _____
 Address City State Zip Code
 _____ \$ _____
 Employer Gross Annual Salary

2. Spouse Information: If the Patient is married, this section must be completed.

_____ Marital Status: Single Married Widowed
 Name Birthdate Social Security Number Separated Divorced
 _____ Phone # _____
 Address City State Zip Code
 _____ \$ _____
 Employer Gross Annual Salary

3. Dependents: (The # of persons the applicant may claim as a personal exemption on the applicant's Federal Income Tax Return.)

Total Number of Dependents: 1. _____ 2. _____
 _____ Dependent's Full Name and Date of Birth _____ Dependent's Full Name and Date of Birth
 3. _____ 4. _____
 _____ Dependent's Full Name and Date of Birth _____ Dependent's Full Name and Date of Birth

4. Assets: Checking/Accounts: _____ Account Balance & Date: _____
 Name and Address of Institution
 Savings/Money Market/CD Accounts: _____ Account Balance & Date: _____
 Name and Address of Institution
 All Vehicles Owned by Model and Year: 1. _____ Tax Assessed Value: \$ _____
 2. _____ Tax Assessed Value: \$ _____
 3. _____ Tax Assessed Value: \$ _____
 4. _____ Tax Assessed Value: \$ _____

5. Other Monthly Income: Total Other Monthly Income: \$ _____

Do you receive SNAP benefits / Food Stamp benefits? Yes / No

SS/SSI \$ _____ Alimony/Foster Care/Child Support: \$ _____ Pension: \$ _____ other: \$ _____

I certify that everything stated in this application and on any attachment is correct. By signing below, I authorize you to verify all information submitted. I agree to immediately supplement my application with any changed financial circumstances. I understand that I cannot apply for financial assistance and financial assistance may be reversed, if I have a pending liability claim, workers comp claim, insurance claim, or my worksheet contains false or incomplete financial information.

Signature: _____ Date: _____