FINANCIAL ASSISTANCE APPLICATION
FOR GREENWOOD COUNTY HOSPITAL

The Greenwood County Hospital offers a Financial Assistance Program to an eligible person based upon ability to pay. Ability to pay is determined by the household size and annual income relative to a discount schedule based upon federal poverty income guidelines.

This program applies to all uninsured and underinsured patients who qualify.

In order to apply for the program, please follow these steps:

1. You must present the following documents. Additional information may be requested if determined during approval process:
   (Please check the documents you are providing)
   - ☐ **Bank statements for past 90 days**
   - ☐ **Proof of income (W-2, Tax Return, Social Security document)**
   - ☐ **Proof of insurance or denial letter from Medicaid**
   - ☐ **Copies of the most recent 90 days of payroll stubs, Social Security checks, or unemployment checks for each member of the household 18 years or older.**
   - ☐ **Current trust fund statements**
   - ☐ **In absence of income, a letter of support from individuals providing for the patient's basic living needs.**
   - ☐ **A list of outstanding medical bills with current statements**
   - ☐ **Most recent copies of electric bill, gas bill, water bill**
   - ☐ **Letter from bank or landlord showing amount of rent or house payment**
   - ☐ **History of prior financial assistance**
2. Return completed application and documentation to the Business Office at Greenwood County Hospital. If you have any questions prior to returning, please contact Kristin Wawrzaszek at 620-583-7451 ext 1073.
3. The application and documents provided will be processed to determine if you are eligible. The discounted rate will be processed and will be in effect for up to one year as determined by Greenwood County Hospital Financial Assistance Team. Financial Assistance will need to be reapplied for upon expiration of approved period.

FINANCIAL ASSISTANCE APPLICATION

1. Please provide the following information for all adults in your household (even if not married).

	Applicant (patient/guarantor)	Co-applicant
Name		
Street Address		
Cit, State, Zip		
Home Phone Number		
Other Phone Number		
Social Security Number (Optional)		
Date of Birth		
Occupation		
Employer		
Employer City		

2. Please list any children/dependent adults living in your household (attach a separate list if more than 4).

Name	Date of Birth	Social Security Number	Relationship

3. Please list monthly income for ALL household members and attach proof of income from W2 or two most recent pay stubs.

	Applicant	Co-applicant	Dependents
Wages	$	$	$
Self-Employment	$	$	$
Social Security	$	$	$
Pension	$	$	$
Unemployment	$	$	$
Workers Compensation	$	$	$
Child Support	$	$	$
Alimony	$	$	$
Food Stamps	$	$	$
Other:	$	$	$
Totals	$	$	$

4. I certify that all information contained on this form (including household income level) is true and correct and hereby authorize Greenwood County Hospital to verify the information in which I have provided. The information received will be held in strict confidence and used only to establish my ability to pay for health care services of Greenwood County Hospital. I also understand that if any information which I submit is determined to be false, I will be held liable for all charges for services provided.
5. I agree that if my income increases or decreases during my approved time that I will notify Greenwood County Hospital to re-evaluate my qualification.
6. If I qualify for a partial discount, I agree to pay the Greenwood County Hospital the discounted balance for each service provided at the Greenwood County Hospital and keep my account in good standing with the Greenwood County Hospital.

Applicant Signature ____ Date: __________________

Co-Applicant Signature ____ Date: __________________

Verification of Income Affidavit

Discount/Sliding Fee Scale Income Thresholds Based on 2022 Annual Poverty Guidelines

Poverty Level	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	A	B	C	D	E	F
1	$0-$13,590	$13,591-$16,988	$16,989-$20,385	$20,386-$23,783	$23,784-$27,180	$27,181 or higher
2	$0-$18,310	$18,311-$22,888	$22,889-$27,465	$27,466-$32,043	$32,044-$36,620	$36,621 or higher
3	$0-$23,030	$23,031-$28,788	$28,789-$34,545	$34,546-$40,303	$40,304-$46,060	$46,061 or higher
4	$0-$27,750	$27,751-$34,688	$34,689-$41,625	$41,626-$48,563	$48,564-$55,500	$55,501 or higher
5	$0-$32,470	$32,471-$40,588	$40,589-$48,705	$48,706-$56,823	$56,824-$64,940	$64,941 or higher
6	$0-$37,190	$37,191-$46,488	$46,489-$55,785	$55,786-$65,083	$65,084-$74,380	$74,381 or higher
7	$0-$41,910	$41,911-$52,388	$52,389-$62,865	$62,866-$73,343	$73,344-$83,820	$83,821 or higher
8	$0-$46,630	$46,631-$58,288	$58,289-$69,945	$69,946-$81,603	$81,604-$93,260	$93,261 or higher
For each additional person, add	$4,720	$5,900	$7,080	$8,260	$9,440	$9,441

	Sliding Fee/Discount Percentages					
	A	B	C	D	E	F
HOSPITAL DISCOUNT	100%	80%	60%	40%	20%	0%

*Based on the 2020 Federal Poverty Guidelines (FPG) for the 48 contiguous states and the District of Columbia.

Application Received Date: ______________________ By: ____

Upon review applicant is:

☐ Ineligible

☐ Eligible ☐ Adjusted percentage (%) ___________

Authorized Signature ____ Date: __________________

Next review date: __________________

NOTES: