LEXINGTON MEDICAL CENTER

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

FINANCIAL ASSISTANCE PROGRAM TYPE B

I. Applicant – Identifying Information

Name: _____

Date of Birth: _____ Social Security #: _____ Race: ____ Sex: ____ Marital Status: _____

Mailing Address or current address: _____ How long at this address? _____

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

Address where you live (if different or prior address if less than 4 months at current address):

_____

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

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

US Citizen: ☐Yes ☐No Permanent Resident: ☐Yes ☐No

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. Are you covered by Medicare? ☐Yes ☐No Medicare Number: _____
4. Do you receive or have you applied for Medicaid? ☐Yes ☐No

   Date applied: _____ If receiving, give Medicaid Number: _____

   What was the reason for denial? _____
5. 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 wages or salary before deductions net receipts from self-employment, regular public assistance payments such as AFDC of 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 not working now, when was your last day of employment? _____
   Employer Name: _____

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

4. 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 family members own real property (home, land, buildings 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 family members own taxable recreational property (mobile homes (other than home), 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 family members own liquid assets (cash on hand, checking or savings accounts, U.S. Savings Bonds, stocks, trust funds, certificates of deposit, IRA's, 401K, etc.)? ☐Yes ☐No

If yes, give the following information:

Type	Name on Accounts	Company Name	Account Number	Amount/Value

VI. Transfer of Resources

Have you or other family member sold or given as a gift any resources in the past 3 months? ☐Yes ☐No

If yes, give the following information:

Resources Sold or Given Away	Name of Persons to Whom it Was Sold or Given	Date	Account Received	Reason for Selling or Giving

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 reporting 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.

Applicant's Signature			Date
Signature of Authorized Representative/ Relationship		Address	Date
Witness Signature	Date	Approving Designee Signature	Date
Interviewer	Date	Company Interviewed	

VIII. Case Notes

_____

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

The eligibility factors identified below must be met before an applicant can be certified for assistance through the LMC FAP. Please indicate if each factor is met and how it was verified.

1. Number of family members

2. Family Income (total gross annual income)

3. Family Resources

   A. Home Property LMC FAP LIMIT
   TOTAL VALUE OF HOME PROPERTY

   B. Non-home real property and taxable personal property LMC FAP LIMIT
   TOTAL VALUE OF NON-HOME REAL AND TAXABLE PERSONAL PROPERTY

   C. Liquid Assets LMC FAP LIMIT
   TOTAL VALUE OF LIQUID ASSETS

Does the applicant's liquid assets exceed the LMC FAP limit? ☐Yes ☐No If yes, by how much? $_____

Did the applicant spend the excess on valid debts of the family which were incurred prior to the date of application or during the applicant's hospitalization? ☐Yes ☐No