

Beaufort Regional Health System

Financial Assistance Screening Application

Purpose: Beaufort Regional Health System is committed to providing medically necessary and high quality health care services regardless of our patient's ability to pay. The hospital acknowledges that there are patients who do not possess the ability to pay for medically necessary services. Those individuals will be provided charity care as established by our Patient Financial Assistance Program.

Procedure: The Patient Financial Services staff will perform a financial screening of all Self Pay or under insured patients. In order to be eligible for financial assistance, you must:

- Have no other source of payment i.e., insurance coverage, governmental assistance with your Hospital bills or savings accounts.
- Have hospital bills beyond your financial resources.
- Provide proof of verifiable income and all income resources.
- Complete a full application and provide all information as required by the Hospital.
- All avenues for any 3rd party reimbursement must have been exhausted prior to the write off. This write off will apply only to the remaining balance on the account.

The following documents must be attached to process your application for Financial Assistance.

- Proof of Income: Prior year tax return or wage verification.
- Social Security statement, if applicable.
- Last month's bank statement.
- Other documents as requested by BRH.
- Signed authorization for Release of Information.

The information provided in this application is subject to verification by the Hospital and has been provided to determine the ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the Hospital. We are providing this assistance as a means to address your outstanding hospital debts. If the information is not provided your account will be referred to an attorney or outside collection agency.

BRH RESERVES THE RIGHT TO PULL A COPY OF YOUR CREDIT REPORT.

Signature of Applicant _____ Date: _____

Hospital Representative _____ Date: _____