Ballad Health Application for Financial Assistance

Application Date:		Patient's Name:										
Social	Security #:	_DOB:	Guarantor #:									
Accou	ınt Number(s),		,									
Please provide all documentation listed below that applies. Sign and return to the address listed below. Documentation should include all family members in the household.												
Required Documentation (*Do not send originals * Please use black ink)												
	Last two years of Federal Tax Returns ar form from the IRS.	e required. If you did not fil	e taxes, 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, yo	ou will need to provide the benefit letter.									
	Retirement income, pension, annuity, sh	nort/long term disability, or	worker's compensation.									
	If you receive Food Stamps, please provi	ide a copy of the approval le	tter.									
	Stocks, Bonds, CD's and Mutual Funds											
	If you own your home, you must provi	de copies of your most rec	ent mortgage statement.									
	Provide the most recent copy of your che statements.	ecking, savings, and Health S	Savings 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:

Po Box 746465 Atlanta, Ga 30374



								balla	id Health	
Patient Full Name	Date of Birth Resp					esponsible Party (Spouse/Guardian/Guarantor)				
Address (Physical Address)	Zip Cod	Zip Code			City					
Social Security No.		Home Telep	Home Telephone No. M		rried ()	Single ()	Separated	()	Divorced ()	
Homeowner () Ren		Month	nly Paym	ent	Approxi	mate Value \$				
	T = 1 ::									
Employer (Name & Address) q Unemployed		Tel.#	Tel.# Emp		np. Since		Monthly Income			
Are any of the accounts listed due		•	•	njury?	Yes() No (()				
If yes, please provide the followin Policy Number:				ey Name		Pho	one Number:_			
En avga Information										
Spouse Information Name:		Social Seco	urity No.							
Employer (Name and Address)			Tel.#	:	Emp.	Since	Mo	nthly Inc	come	
Dependents Name	Data of Divide	D-1-4:			T	I D	-4£ D:-4-	D -	1-4:1-:	
Name	Date of Birth	Relationship		Name		D;	Date of Birth R		lationship	
Monthly Expenses	<u> </u>		Monthly Income			Г	Assets			
Mortgage/Rent \$	<u> </u>	Patient		\$			Checking Acc		\$	
Electric \$ Water \$	<u> </u>	Spouse Social Se	a anni te r	\$		-	Savings Account \$ Health Savings Account \$		\$	
Γelephone/Cell \$		Disability		\$		-	8		\$	
Food \$	_	Unemplo		\$			Property \$			
Clothing \$	\$ Child Suppo			\$			Other \$			
to payment(s) \$		Alimony		\$		-				
Child Care \$		Food Sta		\$		I			1	
	<u>—</u>		Worker's Compensation			Г	Additional As	reete I	Estimated Value	
			ls, Interest	\$		-	Auto #1	55015 1	\$	
		Other Inc	come	\$		-	Auto #2		\$	
l						-	Motorcycle #	1	\$	
ı									\$	
'								2	J)	
'						-	Motorcycle #	2	\$	
al Number in Household:						-	Motorcycle #			
al Number in Household:		Total In	come	\$		-	Motorcycle # Boat		\$	
icant's statement: I do hereby certify the this application. I also understand that ent/guardian/guarantor has the ability e companies contracted by Ballad Healt	Ballad Health has the to pay for their serv	n this form is correct a right to reverse its do rices. I am giving Ball	and true to the ecision concerr lad Health per	best of m ning charit mission to	ty discounts who	en discovery edit file and	Motorcycle # Boat Recreational formation has be of information i	Vehicle een conce s made th	\$ saled or omittenat indicates th	
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