MUSC Health
Medical University of South Carolina
One Poston Rd., Suite 300
Charleston, SC 29407

Today's Date:

Patient Name:

MUSC HEALTH
Application for Financial Assistance

Medical Record # _____**Date of Birth** _____ **Marital Status** _____

Patient Name _____ **SSN Last Four Digits** _____

***Guarantor** _____ **SSN** _____ **Email Address** _____
Responsible for Patient's Balance

Work Phone _____ **Home Phone** _____ **Cell Phone** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Guarantor's employer _____
Employer Name/Address/Phone Number/Date of Hire for Guarantor and Spouse

Guarantor, if not working, when was your last date of employment? _____

Spouse's employer _____
Employer Name/Address/Phone Number/Date of Hire for Guarantor and Spouse

Spouse, if not working, when was your last date of employment? _____

Are you a South Carolina Resident? Yes or No

Are you a U. S. Citizen? Yes or No
If YES, you must provide a legible copy of a valid S. C. Driver's License or a valid S. C. picture ID. If NO, you must also provide a legible copy of a valid Green Card

List all household members/dependents as claimed on your Federal Income Taxes. If a person listed below is not claimed on your taxes, you must provide at least one of the following documents for each person: Birth Certificate, Immunization Record, Social Security Card, Current Medicaid Eligibility Letter, Custody Records or Legal Guardianship Document, School Records OR any reasonable document which shows the parent/guardian-child relationship. If you require more lines than are available on this form, use the Dependent Statement form included in this packet. Income Source includes the gross income form the following sources: Wages, SSI, SSA, Disability Income, Worker's Comp, VA benefits, Retirement/Pension, Child Support, Alimony, Unemployment, Dividends, Annuity Payments, (Gross: Self-Employment Income, Rental Income, Partnership Income), Interest, Sale of Stocks, Foster Care of Adoption Income

Name	SSN Last Four Digits	Relationship to Applicant	Date of Birth	Income Source	Gross Income (Monthly)	Income Source (Employer, SSI, etc)
Guarantor					$	

					$	
Spouse					$	
					$	
Dependent					$	
Dependent					$	
Dependent					$	
Dependent					$	
Total Income					$	

I, the undersigned, do hereby certify that I have read or had read to me all of the statements on this application and that the information I have provided is true and accurate to the best of my knowledge and agree to report any changes.

I further authorize the release of any information, including financial information, needed to determine my eligibility for the MUSC Health Financial Assistance Program. I understand and hereby further authorize the Medical University of South Carolina, the Medical University Hospital Authority, Medical University Physicians, their affiliates, their collection agencies or attorneys to verify the information contained in this application, including obtaining and reviewing my credit reports or that of the patient, guarantor and/or responsible party. I understand that I may be asked to provide additional supporting documents to verify my South Carolina residency, the number of dependents I am claiming and proof of income to aid in the determination of my financial status.

I understand that my eligibility for this discount program is for a one (1) year period contingent upon maintaining eligibility. I must reapply to renew past this coverage year. I also understand that any discount may be withdrawn should my financial condition change.

Signature _____ **Date** _____

Please sign and date this application.

Mail this completed form with required documentation (see list below) to: MUSC Health, 1 Poston Road, Suite 350, Charleston SC 29407.
You may also apply Online at: mychart.muschealth.com.

Approved Document List for the Financial Assistance Program

I. IDENTITY: (PROVIDE ONE OF THE FOLLOWING) – must have applicant's picture

- ☐ South Carolina driver's license
- ☐ State I.D. card (from any state)
- ☐ Employee badge
- ☐ Alien registration card or resident visa, green card
- ☐ Passport
- ☐ Student I.D. card or Military I.D. card

II. RESIDENCY: (PROVIDE ONE OR MORE) – must have current address

- ☐ Current South Carolina driver's license
- ☐ Current utility bill or utility receipt (no more than 30 days old) - gas, water, electric, cable, or land line telephone or cellular telephone
- ☐ Social Security award letter or current check stub
- ☐ Current Medicaid eligibility letter
- ☐ Current complete bank statement, current complete savings statement
- ☐ Current billing statement or business mail from county or city tax notices
- ☐ Current rent receipt or lease agreement which indicates address
- ☐ Voter's registration card
- ☐ Vehicle registration
- ☐ Mortgage documents or Loan documents (car, boat, etc.)
- ☐ Current military orders detailing active duty assignment in South Carolina or letter from your Military Base Commander verifying duty station in South Carolina
- ☐ If you are living with a relative or friend, you must have the Support/Provider Statement attached completed, along with any proof of residence listed above

III. DEPENDENTS: (INCLUDING SPOUSE AS A DEPENDENT) – IF NOT SHOWN ON TAX RETURN, PROVIDE ONE OF THE FOLLOWING:

- ☐ Current Medicaid eligibility letter
- ☐ Social Security card(s)
- ☐ Immunization record
- ☐ Birth Certificate(s)
- ☐ Custody records or legal guardianship document

- ☐ **School records**
- ☐ **Any reasonable document which shows the parent (guardian)-child relationship**

IV. INCOME: (PROVIDE ALL THAT APPLY)

- ☐ **One month of pay stubs (if paid weekly provide the four (4) most recent paycheck stubs; two (2) stubs if paid biweekly; one (1) stub if paid monthly OR current letter from employer on company letterhead OR fill out the Employee Verification Statement attached**
- ☐ **Most recent, complete bank statements (current checking, savings, interest income, trusts or dividends)**
- ☐ **Current retirement income check stub(s), pension or annuity income**
- ☐ **Current Social Security award letter OR Disability Benefit Award Letter for both spouses and any children**
- ☐ **Current Veterans Administration award letter(s)**
- ☐ **Current child support statement (stub(s) or divorce decree) OR complete the Alimony/Child Support Statement attached**
- ☐ **Current documentation from the South Carolina Employment Commission showing weekly benefits or denial of benefits**
- ☐ **Current previous year 1040 Federal income tax form with ALL Schedules and attachments**
- ☐ **Current letter of support from civic organization, church group or other organization on organization's letterhead**
- ☐ **Current Support/Provider Assistance Statement attached, if unemployed**
- ☐ **Current proof you are receiving Subsidized Section 8 housing, current food stamps award letter**
- ☐ **Employment status statement attached**

We appreciate the opportunity to assist you and request that you gather the requested documentation quickly, as the application must be returned *completed* with *all* paperwork within thirty (30) days.

MUSC Health
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MUSC/CMH/UMA
Alimony/Child Support Statement

Statement of Alimony

☐ I, _____ , certify that I receive Alimony in the
(PRINT APPLICANT'S NAME)

amount of $_____

_____ Monthly
_____ Weekly
_____ Bi-Weekly
_____ Twice per Month

☐ I, _____ , certify that I do **NOT** receive Alimony.
(PRINT APPLICANT'S NAME)

_____
SIGNATURE OF APPLICANT/DATE

_____
TELEPHONE NUMBER

Statement of Child Support

☐ I, _____ , certify that I receive Child Support in the
(PRINT APPLICANT'S NAME)

amount of $_____

_____ Monthly
_____ Weekly
_____ Bi-Weekly
_____ Twice per Month

☐ I, _____ , certify that I do **NOT** receive Child Support.
(PRINT APPLICANT'S NAME)

_____
SIGNATURE OF APPLICANT/DATE

_____
TELEPHONE NUMBER

MUSC Health
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MUSC/CMH/UMA
Employment Status Statement

I, _____ certify that I have not worked since _____.
(PRINT APPLICANT'S NAME) (LAST DATE OF EMPLOYMENT)

Answer the following statements that apply to your circumstances:

☐ **I received unemployment compensation for _____ to _____**
(DATE) (DATE)

in the amount of $ _____ per week.

☐ **I have not received unemployment compensation.**

I should return to work _____ .
(DATE)

If not employed, provide the reason for your unemployment:

_____.

_____
(SIGNATURE OF APPLICANT)

_____
(DATE)

I understand that if I have deliberately given false information regarding my employment circumstances, my agreement with MUSC/CMH/UMA will be immediately terminated. By my signature, I authorize the release of any/all information needed to determine my eligibility for the MUSC/CMH/UMA Financial Assistance Program

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MUSC/CMH/UMA
Employment Status Statement

I, _____ certify that I have not worked since _____.
(PRINT SPOUSE'S NAME) (LAST DATE OF EMPLOYMENT)

Answer the following statements that apply to your circumstances:

☐ **I received unemployment compensation for _____ to _____**
(DATE) (DATE)

in the amount of $ _____ per week.

☐ **I have not received unemployment compensation.**

I should return to work _____ .
(DATE)

If not employed, provide the reason for your unemployment:

_____.

_____
(SIGNATURE OF SPOUSE)

_____

(DATE)

I understand that if I have deliberately given false information regarding my employment circumstances, my agreement with MUSC/CMH/UMA will be immediately terminated. By my signature, I authorize the release of any/all information needed to determine my eligibility for the MUSC/CMH/UMA Financial Assistance Program

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MUSC/CMH/UMA
INCOME DECLARATION STATEMENT

CHECK THE APPROPRIATE RESPONSE TO COMPLETE THE FOLLOWING STATEMENTS:

I, _____ :
(PRINT APPLICANT'S NAME)

DO	DON'T	
☐	☐	HAVE A CHECKING ACCOUNT (CURRENT COPY REQUIRED)
☐	☐	HAVE A SAVINGS ACCOUNT (CURRENT COPY REQUIRED)
☐	☐	RECEIVE FOOD STAMPS (APPROVAL LETTER REQUIRED)
☐	☐	RECEIVE SUBSIDIZED HOUSING BENEFITS (COPY OF CONTRACT REQUIRED)
☐	☐	RECEIVE TANF (CURRENT TANF CHECK STUB REQUIRED)
☐	☐	RECEIVE ABC VOUCHERS (CURRENT COPY REQUIRED)
☐	☐	FILE A FEDERAL TAX RETURN FOR THE PREVIOUS YEAR (COPY OF MOST RECENT TAX RETURN AND ALL SCHEDULES REQUIRED)
☐	☐	HAVE A DISABILITY CLAIM OR AN APPEAL PENDING (PROVIDE CURRENT PROOF OF CLAIM PENDING OR APPEAL LETTER)
☐	☐	RECEIVE CHILD SUPPORT (IF YOU DO, THE FORM INCLUDED IN THIS APPLICATION PACKET MUST BE COMPLETED)
☐	☐	RECEIVE ALIMONY (IF YOU DO, THE FORM INCLUDED IN THIS APPLICATION PACKET MUST BE COMPLETED)

_____
(APPLICANT'S SIGNATURE/DATE)

COPIES OF DOCUMENTS MUST BE SUBMITTED WITH APPLICATION OF ALL THAT APPLY

MUSC Health
Medical University of South Carolina

MUSC/CMH/UMA
SUPPORT/PROVIDER ASSISTANCE STATEMENT

This form must be completed if you have low income, are unemployed or have a claim pending for disability and must be completed by the person(s)/organization providing the applicant support.

I, _____, provide food, lodging and other basic necessities
(PRINT PROVIDER'S NAME)

for _____.
(PRINT APPLICANT'S NAME)

☐ I certify that I do claim the applicant as a dependent on my income taxes.

☐ I certify that I do NOT claim the above named patient as a dependent on my income taxes.

_____
PRINT PROVIDER'S NAME AND RELATIONSHIP TO APPLICANT

_____
PROVIDER'S ADDRESS AND TELEPHONE NUMBER

_____
PROVIDER'S SIGNATURE AND DATE