Financial Assistance Application

Patient Name *(Last, First, Middle)*	Social Security Number
South Carolina Resident: ☐Yes ☐ No Travel Visa: ☐Yes ☐No	
U.S. Citizen: ☐Yes ☐ No Medical Record Number (office use only):	

Patient or Responsible Party (If patient is under age 18)

Name *(Last, First, Middle)*		Social Security Number	Birth Date*(MM, DD,YYYY)*
Address		City	State, Zip Code
Phone	Household Size (Patient, Spouse and Dependents)		Marital Status
Employment Status: ☐Full Time ☐Part Time ☐Self-employed ☐Unemployed ☐Student ☐ VA ☐Disabled		Employer Name	
How Long Employed	How Long Unemployed *(MM, DD,YYYY)*	Salary/Income	Are you claimed on another tax return? ☐Yes ☐No (If yes provide tax returns of those being claimed)
South Carolina Resident: ☐Yes ☐ No Travel Visa: ☐Yes ☐No			
U.S. Citizen: ☐Yes ☐ No			

Spouse/Life Partner

Name *(Last, First, Middle)*		Social Security Number	Birth Date*(MM, DD,YYYY)*
Employment Status: ☐Full Time ☐Part Time ☐Self-employed ☐Unemployed ☐Student ☐ VA ☐Disabled		Employer Name	
How Long Employed	How Long Unemployed *(MM, DD, YYYY)*	Salary/Income	

Legal dependents as claimed on tax return (If more than 4 dependents use separate page)

Full Name *(Last, First, Middle)*	**Relationship**	**Birth Date*(MM, DD,YYYY)***

Coverage Information

I have ☐Applied for federal or state medical assistance ☐Verified my healthcare exchange plan eligibility ☐Neither
Reason_____

I have a ☐Lawsuit ☐ Settlement ☐Personal Injury Claim ☐Liability Claim ☐Workers' Compensation Claim ☐None
Attorney Name _____

Insurance is available through: ☐My employer ☐Spouse's employer ☐Cobra ☐None
Insurance Information _____

Have you or a family member applied for Medicaid within the last 3 months? ☐Yes ☐ No

Who Applied _____ County Applied In _____

Date Applied _____ Caseworker Name _____

I have applied for Social Security Disability. ☐Yes ☐ No
If applied, Status: ☐Denied ☐Appeal ☐Attorney Level ☐Pending ☐ Approved
If recently awarded, attach current social security award letter or Disability Benefit Award Letter to spouse and any children

Bank Account(s) (e.g. 401k, 403b, Money Market, CD, Stocks, Bonds, Savings, Other Investments)

Company Name	Account Type/Value	Company Name	Account Type/Value

Property

Type	Detail	Estimated Value	Unpaid Balance
Primary Residence	☐Own ☐Rent		
Secondary Residence/Vacation Home			
Land (number of acres)			
Rental Property			
Business/Farm Equipment			
Other/Recreational Vehicle(s)			

Sources of Income (Provide documentation for any of the following)

Income Description	Source	Monthly Income Amount
Interest/Dividends		
Pension/Retirement		
Rental/Property		
Investments		
Self-employment (requires Business & Individual Tax Returns)		
Other		

Attestation

I understand that this application applies only to services provided by Prisma Health. This does not apply to services provided by others who may have assisted with my care. I understand that not all medical services at Prisma Health qualify for financial assistance.

Prisma Health reserves the right to reverse financial assistance approval and pursue alternate reimbursement or collections as a result of newly discovered information, including insurance coverage, payment to the applicant, or pursuit by applicant of a personal injury claim related to the services received or requested. All payments received by Prisma Health after financial assistance is awarded will result in the reversal of the adjusted amounts to resolve the remaining self-pay balance without creating a balance due or a credit balance.

I hereby certify that the information in this application is true and correct to the best of my knowledge. I understand that providing incorrect information may result in this application being denied. Should the information provided on this application be determined at any time to be incorrect, the financial assistance provided to me by Prisma Health may be revoked and I will be responsible for the original account balance. I further understand that if any information I provided should change, I will promptly notify Prisma Health.

Patient/Responsible Party Signature	Date *(MM, DD, YYYY)*

Return application to:
Financial Assistance
255 Enterprise Boulevard, Ste. 250
Greenville, S.C. 29615