For Internal Use

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TIDELANDS HEALTH
FINANCIAL ASSISTANCE APPLICATION

Please read the application in its entirety and attach ALL required information that applies to your situation on page two. Incomplete applications will not be accepted and may result in denial.

The application requires information on the patient along with other qualified members of the household/immediate family. The approval or denial of this application is based on the number of dependents along with the total income and the value of assets within the household. Applicants who may qualify for government assistance will be notified and asked to cooperate in full with the other program(s). If the applicant is denied government assistance for a valid reason, financial assistance will be reconsidered. **If your account(s) are the result of a motor vehicle accident and there is a possible settlement, charity assistance will not be available. No child under the age of 19 potentially eligible for Medicaid will be considered for financial assistance without receipt of a valid Medicaid denial letter.**

The application cannot be completed without verification of income and liquid assets. Please reference the attached list of required verifications. Your application will be denied if you do not provide ALL of the required information. If the application is denied due to missing information, the patient will be contacted and has 30 days from the date of rejection to return all requested information. If all required information is not returned in time, the application will be completely denied. You must sign and date the application before consideration is made of your request.

All applications will receive a fair evaluation by our business office. All decisions are final, and there is no appeal process.

You may return your application to us via fax at the number below, or by mail at the following address:

Tidelands Health
ATTN: Financial Assistance
PO BOX 421718
Georgetown, SC
29442-1718
ph: 843.520.8880
fx: 843.520.8403

Thank you for your cooperation.

Sincerely,

Tidelands Health Charity Coordinator

VERIFICATION LISTING

PLEASE READ THE APPLICATION IN ITS ENTIRETY.
IF YOU DO NOT INCLUDE ALL OF THE REQUIRED INFORMATION (AS APPLICABLE) OR COMPLETE ALL SECTIONS, YOUR APPLICATION WILL BE DENIED.

If you have a child in the home under the age of 19 and there is potential for eligibility of Medicaid, a Medicaid denial letter must be reviewed before charity assistance is considered.

If you are eligible for any other assistance such as Medicaid, worker's compensation, crime victims, MIAP, etc., these programs must be reviewed prior to consideration of this charity program.

Last year's federal tax return (Form 1040) including all schedules and attachments. If you did not file last year's taxes, the most current years return must be provided. If, for any reason you do not file taxes, please provide an explanation of why.

Last year's federal tax return including all schedules and attachments for any business that you fully or partly own.

Verification of income from the following (as applicable):

- Statement of wages for the past 8 weeks for all wage earners. These must be back to back dates. W-2's are not sufficient for proof of wages / income.
- Social Security or Veteran's Administration documentation stating how much you (and/or other family members) receive each month. You should provide the award letter you received when your benefits were issued.
- Statement of wages for anyone in the household receiving unemployment, worker's compensation, child support, alimony, pension, retirement, other interest income or any other income for yourself and / or the household.
- If you currently do not have any income, please provide a letter of financial support from the person(s) that are currently supporting you.

Copy of the most recent tax assessment for all real property. Included but not limited to house, land, life estate, mobile home, condominium, time-share, building, etc.

Copy of your most recent mortgage statement listing the total outstanding loan amount from your financial institution.

Copies of the 2 most recent statements for each liquid asset from the financial institution. Included but not limited to checking and savings accounts, certificates of deposit, annuities, trusts, mutual funds, stocks, bonds, IRA's, 401k, 403b, retirement accounts, etc. These statements must contain all pages with transactions and details.

Tidelands Health

FINANCIAL ASSISTANCE APPLICATION

Section I – Patient Information

Name: _____
Date of Birth: _____ SSN: _____ Martial Status: _____
Spouse's Name (if applicable): _____
Date of Birth: _____ SSN: _____
Home Phone: _____ Alternate Phone: _____
Email: _____
Home Address: _____

City: _____ State: _____ Zip: _____
Mailing Address (if different): _____
City: _____ State: _____ Zip: _____

County of Residence: _____

Preferred Method of Contact: US Mail Email Phone

Section II – Dependents

** If the bill is for some one under the age of 19, please contact your local Medicaid Office **

Name of Person	Relationship	Social Security #	Date of Birth

Section III – Medical insurance

Does anyone in the home currently have medical insurance?

Yes No

Name of Person	Insurance Company	Policy #

Section IV – Income

Do you or anyone in the home currently have an income?

Yes No*

Income includes wages or salary before deductions, unemployment compensation, child support, social security, Veteran's benefits, pension or other retirement income, Alimony, gross receipts from self employment, regular public assistance payments such as AFDC or SSI, worker's compensation, interest income, etc.

***** If you do not have an income, please provide a letter of financial support.

Please attach adequate verification of the income listed below along with the most recent Federal Tax return.

Name of Person	Gross Yearly Income	How often paid?	Source of Income

Section V – Real Estate

Do you or anyone else in the home own real property?
(House, land, life estate, mobiles home, condo, time-share, buildings, etc)

Yes No

Do you own (fully of partly) a business which owns real property?

Yes No

Please attach copy of county tax assessments along with the most recent mortgage statement.

Type of Property	Owner's Name	Location or Property	Amount Owed on Property

Section VI – Liquid Assets

Do you or anyone else in the home have liquid assets?

Yes No

Please attach copies of the last 2 most recent statements for each asset below.

Type of Asset	Y/N	Owner's Name	Institution	Balance/Value
Cash on Hand				
Checking Account(s)				
Savings Accounts(s)				
Certificate(s) of Deposit				
Annuities/Trusts Stocks/Bonds				
401k/403b/IRA/etc				

Do you or anyone else in the home own a business with liquid assets?

Yes No

If yes, what percentage of the business do you own? _____%

Please attach copies of the last 2 most recent statements for each business asset below.

Type of Asset	Y/N	Owner's Name	Institution	Balance/Value
Cash on Hand				
Checking Account(s)				
Savings Accounts(s)				

Section VII – Applicants Additional Information

If the applicant has any special circumstances which they would like for Tidelands Health to consider in the application, please explain it below:

_____

_____

_____

_____

_____

_____

Section VIII – Statement of Understanding

I understand that my case is confidential and no information will be released unless I authorize it.

I understand that by applying for or receiving assistance through the Tidelands Health Charity Program, I will automatically assign to Tidelands Health any amount which I may be entitled to recover from any third-party or private insurer, not to exceed the amount of the charity reduction of my bill(s).

I certify that I have read, or had read to me, all statements on this application 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 my situation, I am liable for prosecution for fraud. By my signature I authorize the release of any information, including credit reports, needed to determine my eligibility for the Tidelands Health Charity Program.

Applicant Signature: _____ Date: _____

FINANCIAL ASSISTANCE GUIDELINES

FAMILY SIZE	GROSS ANNUAL INCOME LESS THAN (200% OF POVERTY)	PATIENT RESPONSIBLE FOR 0% OF CHARGES
1	$ 29,160	
2	$ 39,440	
3	$ 49,720	
4	$ 60,000	
5	$ 70,280	
6	$ 80,560	
7	$ 90,840	
8	$ 101,120	
EACH ADTL FAMILY MEMBER:		$ 10,280

Effective Date: 02/01/2023