



Financial Aid Application

Dear Patient or Guarantor,

Thank you for choosing Weems Memorial Hospital for your healthcare needs. The Patient Financial Services department would like to assist you with your financial obligation, by offering the Financial Assistance application. If you have any questions about the required documents or the application, please feel free to ask an admission clerk or call our Financial Counselor at 850-653-8853 ext. 118.

If you have circumstances which you feel are important to your financial situation, please include a signed letter of explanation with the documents.

Required Documents:

1. Medicaid denial letter, if requested by Weems Memorial Hospital or Patient Financial Services.
2. Last year's tax return or your most recent W2 (If your income has changed since your last tax return, please provide a written explanation.)
3. Proof of income (at least one of the following):
 - a. 2 previous paycheck stubs
 - b. Unemployment compensation letter
 - c. Disability benefits letter
 - d. If your income is from a retirement fund, pension, rental property, etc. provide proof of income source and the amount received.
4. Rent or mortgage payment receipt for one month
5. Utility bills: gas, electric, water and sewage
6. Copy of photo ID (driver's license, state ID card, passport)

Please return the completed, signed, and dated application along with the list of supporting papers within 2 weeks.



Financial Aid Application

Patient and/or Guarantor information if patient is a minor:

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____

Social Security #: _____ Marital Status: _____

Employer: _____ Position: _____

Annual Salary: _____ Length of Employment: _____

Health Insurance Company: _____ Policy #: _____

Spouse and/or Legal Guardian Information:

Name: _____ Date of Birth: _____

Employer: _____ Social Security #: _____

Annual Salary: _____ Position: _____

Dependent (s) Information:

Number of Dependents: _____

Name: _____ Date of Birth: _____ Relationship: _____

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Name: _____ Date of Birth: _____ Relationship: _____

Use a separate sheet of paper if necessary:



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Disclaimer and Authorization:

I authorize George E. Weems Memorial Hospital to obtain a consumer credit report on my behalf to process my application, if necessary. This information will only be used for the purpose it was intended.

I understand that George E. Weems Memorial Hospital will not share or disclose the information with any third party vendor unless I give the proper authorization.

George E. Weems Memorial Hospital will not give me a copy of my credit report; it will stay in the hospital financial record.

I authorize George E. Weems Memorial Hospital to verify all the information given by me in order to process my application.

Applicant's Name _____

Applicant's Signature _____

Date: _____