Calhoun-Liberty Hospital
Financial Assistance

Dear Patient/Guarantor,
Thank you for choosing Calhoun-Liberty Hospital for your healthcare needs. We are proud to offer a variety of payment options to assist you with your financial obligations, including prompt pay discounts, payment arrangements, pay-by-phone, and automated payments.

Please contact our Financial Counselor at **850-237-3025** to make payment arrangements and/or assist you with any questions concerning your bill.

If you would like to be considered for assistance with your bill, please complete the Financial Assistance Form and return it, along with the requested documentation. You may turn in your application by mail, fax, or at the billing office or any registration desk.

Financial Assistance Application Required Documents:

Proof of Income—for everyone living in household
- If employed—paycheck stubs for at least one month, not older than 3 months from the date of your application.
  - If you are unable to provide pay stubs you will need to provide a letter from your employer stating one month's gross salary.
- If receiving unemployment—provide check stub from unemployment compensation or unemployment determination letter.
- If receiving income from a retirement fund, pension, alimony, child support, rental property, etc. provide proof of the source and the amount of income received.
- Proof of disability or physicians work order restrictions if applicable

Most current tax return (W2, 1099, etc.)
- If income has changed since last year provide a written explanation.

Rent or mortgage bill for one month, not older than 3 months from the date of your application.
Utility Bills: electric, water, sewage, gas, etc.
Outstanding medical bills from other facilities (not including Calhoun-Liberty Hospital).

Please note that you must return all the required documentation for your application to be considered. If you are unable to provide any of the items listed you must include a letter explaining why you were not able to provide that information.

Mail or fax the completed application along with required documents to:

Calhoun-Liberty Hospital
Attention: Selfpay Coordinator
20370 NE Burns Avenue
Blountstown, FL 32424

Fax: 850-674-1649

Phone: 850-237-3025

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Complete all sections below. If a question is not able to be answered you must list the reason.
If additional space is required you may attach a separate sheet of paper.

Section 1: Guarantor Information

The Guarantor is the patient or the person who is financially responsible for the patient's bills.
Note: If the patient is a minor this should be the Guarantors information.

Guarantor Name:		Social Security Number:	
Address:		Birth Date:	
City, State, Zip:		Home Phone Number:	
Cell Phone Number:		Work Phone Number:	
Marital Status: (Circle One)	Single Married Divorced Separated Widowed		

Section 2: Household and Dependent Information

Complete for everyone living in the household: spouse, children under age 18, college students, etc.
Note: Include all forms of income in total—gross wages, child support, retirement, social security, etc.

Name	Relationship to Guarantor	Total Monthly Gross Income	Social Security Number	Date of Birth

Guarantor Notes: You may list any notes or circumstances you would like to be considered with your application.

Declaration: The information provided above is, to the best of my knowledge and belief, complete, accurate and true. I authorize release of all information for which Calhoun-Liberty Hospital may need to determine whether I qualify for financial assistance. I agree to immediately notify Calhoun-Liberty Hospital if my insurance, income, or demographics change.

Applicant Signature:		Date:	
Spouse Signature:		Date:	