Elbert Memorial HOSPITAL

4 Medical Drive, Elberton, GA 30635
Phone: (706)283-3151
Patient Financial Services FAX: (706)-283-8609
www.emhcare.net

Financial Assistance Application Form

Patient/Guarantor:	ACCT#:	DOB:
Address: City/State:		Zip Code:
Home Phone:	Cell Number:	County:

LIST ALL HOUSEHOLD MEMBERS

Name	Date of Birth	Relation to Patient	Sex/Race
			/
			/
			/
			/
			/

Current Employment:	**Phone: - -**	**Weekly/Bi-Weekly/Monthly$ Hours per pay period:**
Job Title:		**Date of Employment:**
Spouse Employment:	**Phone: - -**	**Weekly/Bi-Weekly/Monthly$ Hours per pay period:**
Job Title:		**Date of Employment:**

Gross Income	**Patient Income (Annually)**	**Spouse Income**
Wages	$	$
Social Security Retirement	$	$
Social Security Disability/SSI	$	$
Veterans Benefits	$	$
Unemployment	$	$
Other Income	$	$

Signatures

I hereby certify that the information provided in this Patient Financial Statement is true, accurate and complete to the best of my knowledge. I hereby authorize the Hospital to contact any person, firm or organization to verify any of the information given and I hereby authorize any such person, firm or organization to release to the Hospital any financial information it may request.

Patient/Guarantor:	Date:	Witness: