COH Atlanta Financial Assistance Evaluation Form

As part of our commitment to serve the community, COH elects to provide financial assistance to patients who are uninsured or under-insured and satisfy certain requirements.

Financial assistance is not considered to be a substitute for personal responsibility, and patient families are expected to cooperate by providing complete and accurate information so COH can determine a patient's eligibility for our financial assistance program, and to contribute to the cost of the patient's care based on individual ability to pay.

Individuals who are eligible to apply for public assistance, as well as individuals with the capacity to purchase health insurance, will be encouraged to do so as a means of assuring access to health care services.

To determine if a patient qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Applicant Information

Full Name: _____ _____ ____ _____
Last *First* M.I. Date of birth

Address: _____ _____
Street Address *Apartment/Unit #*

City _____ *State* _____ *ZIP Code* _____

Phone: _____ Email: _____

Med Rec#: _____ Social Security#: _____ Annual Household Income: _____

Employed? Yes / No

Employer Info:

_____

Does the patient have Health Insurance? Yes / No

Has the patient applied for Medicaid? Yes / No If Yes, date patient applied: _____

Is the patient on Social Security Disability? Yes / No

Additional Info:

_____

_____

Dependent Information

Number of Dependents: _____ Ages: _____

Spouse/Partner/Guarantor Information

Spouse/Partner/Guarantor: Yes / No Employed: Yes / No

Name: _____ Employer: _____

Relationship: _____ Email: _____

Disclaimer and Signature

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification, including the use of third-party validation programs, and subject to review by federal and/or state agencies and others as required and that at any time during the application process additional information may be requested. I understand that if any information I have given proves to be untrue, City of Hope will re-evaluate my financial status and any assistance granted may be reversed and I will be responsible for the payment of any balances. Any approval for financial assistance will be effective for a maximum of 6 months. A new Application will be required for the re-determination of your eligibility of Financial Assistance after the 6-month approval period.

Signature: _____ Date:_____

Additional Information

Completed forms may be:

- Electronically signed and submitted

OR any of the following

1. Emailed to PtAcctsFinancialHardshipTeam@coh.org
2. Returned to the hospital financial counselors
3. Mailed to:

   COH – Patient Accounts
   2610 Sheridan Road
   Zion, IL 60099

- COH reserves the right to review a credit report for you and your spouse as needed.
- COH may ask for additional documentation including but not limited to W2's, Most Recent Tax Return, Social Security Statement, Proof of life changes, etc.
- COH may review accounts held for outstanding insurance payments that have been sent to the member

Once all information is received, COH will respond within 30 days to your request for financial assistance. Should we need additional information to process your request we will contact you via phone or email. You will be notified by mail of your eligibility once the application and all documentation is received and processed; standard collection procedures will continue until complete information is received.

For status or questions, please contact Patient Accounts at 800-677-5545
Monday through Thursday 8:00 am – 4:00 pm CST or Friday from 8:00 am – 2:00 pm CST.