



**Beaufort Memorial**  
HOSPITAL



*affiliated with*  
**Duke University**  
**Health System**  
*in Heart and Cancer*

**FINANCIAL ASSISTANCE APPLICATION**

Complete this form and mail to  
BEAUFORT MEMORIAL HOSPITAL  
ATTN: FINANCIAL ASSISTANCE  
955 RIBAUT ROAD  
BEAUFORT, SC 29902

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

GUARANTOR ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

NAME OF PATIENT: \_\_\_\_\_

ACCOUNT #: \_\_\_\_\_

GUARANTOR SS #: \_\_\_\_\_

DATE OF SERVICE: \_\_\_\_\_

Does applicant/patient have health insurance?: ( ) Yes ( ) No

Is applicant/patient employed?: ( ) Yes ( ) No

If not employed, what was the date of last employment \_\_\_\_\_

Does applicant/patient collect unemployment?: ( ) Yes ( ) No

If no, has applicant filed for unemployment: ( ) Yes ( ) No

Is applicant age 65 or over?: ( ) Yes ( ) No

Is applicant 19 years of age or younger? ( ) Yes ( ) No

Is applicant legally blind or disabled?: ( ) Yes ( ) No

**LIST EVERYONE IN THE HOUSEHOLD THAT YOU ARE FINANCIALLY RESPONSIBLE FOR INCLUDING SPOUSE AND YOURSELF**

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## FINANCIAL SUMMARY

### INCOME

(after taxes and deductions)

Salary \$ \_\_\_\_\_

Are you paid weekly or every two weeks? (circle one)

Retirement \$ \_\_\_\_\_

SS/Disability \$ \_\_\_\_\_

Child Support \$ \_\_\_\_\_

or Alimony Received.

Food Stamps \$ \_\_\_\_\_

Unemployment \$ \_\_\_\_\_

Spouse Income \$ \_\_\_\_\_

Other Income \$ \_\_\_\_\_

### ASSETS

Cash \$ \_\_\_\_\_

Savings/checking \$ \_\_\_\_\_

Stocks/Bonds \$ \_\_\_\_\_

Briefly explain why you feel that you are financially unable to pay your outstanding account balance at Beaufort Memorial Hospital.

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\*\* Proof of income (tax returns, pay stubs, etc.) may be required prior to application being approved.

By signing below I certify the information provided is true and accurate to the best of my knowledge. False, inaccurate or incomplete information may result in this application being denied.

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Date

### MONTHLY EXPENSES

House/Rent \$ \_\_\_\_\_

Electric \$ \_\_\_\_\_

Water \$ \_\_\_\_\_

Phone/Cell \$ \_\_\_\_\_

Auto PYMT \$ \_\_\_\_\_

Food \$ \_\_\_\_\_

Loans \$ \_\_\_\_\_

Child Support (paid) \$ \_\_\_\_\_

House \$ \_\_\_\_\_

Automobile \$ \_\_\_\_\_

Medical \$ \_\_\_\_\_

Life Insurance: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_