



## Financial Assistance Form

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Please fill out the form below and mail it to one of our financial counselors. Remember to fill out all required fields and to give as much information as possible. This will help in the application process for financial assistance. If you need help in filling out this form, please contact one of our financial counselors.

To send the form to Timmy Buffin or Jacqueline Brown mail form to:

**5565 Peachtree Dunwoody Rd, NE  
Patient Access Services Dept, 5<sup>th</sup> Floor  
Atlanta, GA 30342**

### Financial Counselor Contact Information:

**TIMMY R. BUFFIN**

*Financial Counselor*

5565 Peachtree Dunwoody Rd, NE  
PAS Dept, 5<sup>th</sup> floor  
Atlanta, GA 30342

TEL: 404 -851-7239  
FAX: 404 -851-7126  
trbuffin@sjha.org



**JACQUELINE B. BROWN**

*Financial Counselor*

5565 Peachtree Dunwoody Rd, NE  
PAS Dept, 5<sup>th</sup> floor  
Atlanta, GA 30342

TEL: 404 -851-7859  
FAX: 404 -851-5894  
jbbrown@sjha.org



(see next page for form)



**Statement of Financial Condition  
Schedule of Current Income and Expense**

Denotes Required Field

**PATIENT INFORMATION:**

<u>Patient Name</u>	_____	<u>Phone #</u>	_____
<u>Address</u>	_____	<u>SS#</u>	_____
<u>City, State Zip</u>	_____		

**OTHER INFORMATION:**

<u>Spouse Name</u>	_____
<u>Social Security Number</u>	_____
<u>SS#</u>	_____
<u>Other Name</u>	_____
<u>Relation to Patient</u>	_____
<u>SS#</u>	_____

**FAMILY STATUS: List all dependents that you support**

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**EMPLOYMENT AND OCCUPATION**

<u>Employer:</u> _____	<u>Position:</u> _____
<u>Contact Person &amp; Telephone:</u> _____	
<u>If Self-Employed, Name of Business:</u> _____	
<u>Spouse Employer:</u> _____	<u>Position:</u> _____
<u>Contact Person &amp; Telephone:</u> _____	
<u>If Self-Employed, Name of Business:</u> _____	
<u>Other Employer:</u> _____	<u>Position:</u> _____
<u>Contact Person &amp; Telephone:</u> _____	
<u>If Self-Employed, Name of Business:</u> _____	

**CURRENT MONTHLY INCOME**

	<u>Patient</u>	<u>Spouse</u>	<u>Other</u>
<u>Add: Gross Pay (before deductions)</u>	_____	_____	_____
<u>Add: Income from Operating Business (if Self-Employed)</u>	_____	_____	_____
<u>Add: Other Income:</u>			
<u>Interest and Dividends</u>	_____	_____	_____
<u>Unemployment/Worker's Comp</u>	_____	_____	_____
<u>From Real Estate or Personal Property</u>	_____	_____	_____
<u>Social Security</u>	_____	_____	_____
<u>Other (specify):</u> _____	_____	_____	_____
<u>Alimony or Support Payments Received</u>	_____	_____	_____
<u>Equals: Current Monthly Income</u>	\$ _____ -	\$ _____ -	\$ _____ -
<u>Total Current Monthly Income (add Patient+Spouse Income from above)</u>	\$ _____ -		

**FAMILY SIZE**

<u>Total Family Members</u>	_____
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(add patient, spouse and dependents from above)

**MONTHLY ALLOWABLE EXPENSE INFORMATION**

Rent \_\_\_\_\_  
Utilities \_\_\_\_\_  
Food Allowance \_\_\_\_\_  
Other (other allowable expenses) \_\_\_\_\_

**Medical expenses**

Hospital \_\_\_\_\_  
Doctors \_\_\_\_\_  
Medications \_\_\_\_\_

*Equals:* Total Monthly Expenses \$ \_\_\_\_\_ -

**TOTAL MONTHLY DISPOSABLE INCOME**

Total Monthly Disposable Income \$ \_\_\_\_\_ -

By signing this form, I agree to allow Saint Joseph's Hospital to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be required to provide proof of the information I am providing.

\_\_\_\_\_  
(Signature of Patient or Guarantor) (Date)

\_\_\_\_\_  
(Signature of Spouse) (Date)