EMORY
HEALTHCARE

FINANCIAL ASSISTANCE APPLICATION

Emory Healthcare - Updated April 2026

Patients who are unable to pay for emergency and medically necessary health care services provided by Emory Healthcare may be eligible for financial assistance. If you would like to be evaluated for financial assistance eligibility, please complete and return this Financial Assistance Application form. See Emory Healthcare's *Financial Assistance Policy*, *Plain Language Summary*, and other relevant documents at **www.emoryhealthcare.org/patients-visitors/financial-assistance.html** for more information.

Patient's Name:

____SS#:____________________________________

Gaurantor's Name (if different from patient):

____SS#:____________________________________

Street Address:____

City:____________________ State:_____________ Zip:_________ Phone:___________________________________

Employer:____ Years Employed:__________________________

Are you married? ☐ Yes ☐ No Spouse's Name:____

Number of Dependents *(include yourself)*:__________ Ages:____

Number of Household members:____

Family Income Information (Total income received by the patient, the patient's Family members who are older than 15 years of age, and all Guarantors from all sources; see Financial Assistance Policy for additional information)		
Type of Income	**Patient**	**Spouse/Other Household Member**
Salary ☐ Hourly ☐ Monthly ☐ Yearly *(check one)*	$	$
Unemployment	$	$
Social Security or Disability	$	$
AFDC	$	$
Child Support	$	$
Savings Account	$	$
Checking Account	$	$
Other	$	$

To verify Family Income, please provide the following documents (as applicable) for patient and spouse:

___ Pay Stubs for the last 4 weeks (or employer statement verifying gross wages); or
___ Most recent tax return; or
___ Most recent IRS Form 1040; or
___ IRS W-2 Form (issued during the past year); or
___ Income Award Letter; or
___ Unemployment compensation denial letter; or
___ Most recent two months of bank statements for each checking, savings, money market, or other account; or
___ Documentation or an attestation of all other income for the most recent two months

Requirements for Applying for Financial Assistance

- Patients requesting financial assistance must provide documentation and other information requested by Emory Healthcare, as outlined in Emory Healthcare's *Financial Assistance Policy* and this *Financial Assistance Application*.
- Patients requesting financial assistance must cooperate by applying for public benefits, if applicable, such as Medicaid, Social Security, and disability.
- At any point during the application process, Emory Healthcare may request additional information or documentation to help determine eligibility for Financial Assistance. If the patient's or spouse's financial circumstances change, Emory Healthcare may require a new application.
- Financial Assistance approvals are valid for a maximum of 6 months, but Emory Healthcare reserves the right to review financial assistance eligibility under the *Financial Assistance Policy* at any time and to make adjustments, as needed.
- Providing false, incomplete, or misleading information may result in the retroactive denial or reduction of financial assistance, and patients may be held responsible for the resulting balance.

By signing below, I certify that:

(1) I understand the requirements for applying for financial assistance, as outlined above.
(2) The information I have included in this form is true and correct, to the best of my knowledge.
(3) I understand that Emory Healthcare will use the information in this form to assess my ability to pay for services provided by Emory Healthcare (or an affiliated entity).
(4) I give permission for Emory Healthcare and all affiliated hospitals, clinics, and other entities to share my information as needed to consider my request for financial assistance, consistent with Emory Healthcare's *Financial Assistance Policy*.

Patient's/Gaurantor's Signature: ____ Date:______________

Please print full name: ____

Spouse's Signature (if applicable):
____Date:______________

Please print full name: ____