West Georgia Cardiology

♥129 Bankhead Highway ♥ Carrollton, GA 30117♥
♥Business Office: (678)♥839♥7290 Fax: (678)♥839♥7293♥

PATIENT FINANCIAL ASSISTANCE PROGRAM

Welcome to our PFA program! West Georgia Cardiology provides an opportunity, for patients who qualify, to receive a **discount** for their healthcare services. This program is based on the low income poverty level. Based on those guidelines, we review the patient's income and expenses. Patients may qualify to receive a **discount which reduces their amount due** for the services rendered. ***This program does not provide free services.*** **West Georgia Cardiology is not affiliated with Tanners Indigent Program.** If approved, you will be **REQUIRED** to pay your designated co-pay at the time of service**. There are no exceptions.**

We will need the following information in our office in order to process your paperwork:

- **PFA Application**
- **Denial letter from Medicaid or Tanner Indigent Approval Letter**
- **All household bills**
- **Bank statements (all pages)**
- **Proof of Income for the household such as:**
    - SSI/SSD Benefits
    - VA Benefits
    - Tax Returns
    - Paystubs
    - Food Stamps Approval Letter
- **If no income, then a notarized letter from the person that is paying your bills, as well as proof of income for that person.**

Once all of the documents are received please allow seven business days for your application to be evaluated. This information assists us in determining the level at which you qualify and the amount of discount that you are eligible to receive. This program is only available to patients who do not have any healthcare coverage and do not qualify for benefits provided by the Department of Family and Children's services and or Medicaid assistance.

You will receive a call from our office as well as a letter explaining your eligible amount due that you will be **required** to provide at the time services are rendered. Any past balances will be adjusted accordingly and a payment arrangement can be made. **Please be advised that all PFA benefits expire per calendar year. You will need to re-apply in January of the following year to continue in the program.**

If you have any questions please call our office at 678-839-7290. Thank you.

Date: ____/____/____

Patient Name: ________________________________ Number in household: _________

Names & Dates of Birth for all household members:

____

____

____

Patient Address: ____
City: _____________________________________ State: ____________ Zip Code: ___________
Employer: ______________________________ Phone Number: (____) _______-___________
Employer's Address: ____
Contact Person: ____

Spouse Name: ___________________________ Phone Number: (____) _______-___________
Employer: _______________________________ Phone Number: (____) _______-___________
Employer's Address: ____
Contact Person: ____

INCOME DESCRIPTION:		**EXPENSE DESCRIPTION:**	
Salary – Patient:	$___________	Rent:	$___________
Salary – Spouse:	$___________	Electric:	$___________
Pension Income:	$___________	Water:	$___________
Self Employment:	$___________	Phone:	$___________
Social Security:	$___________	Gas:	$___________
VA Benefits:	$___________	Child Support:	$___________
SSI Benefits:	$___________		
Child Support:	$___________		
Alimony:	$___________		
Food Stamps:	$___________		
Total Income:	$___________	Total Expense:	$___________

Please be advised you must provide proof of all income and expenses listed.

Have you applied for Georgia Medicaid in the last twelve months? ___________________

I certify the above information is true and correct:

Applicant Signature: ____________________________________ Date: _____/_____/_____

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Contract:

_______ I am applying for the PFA program and I understand that this program only provides a discount, not free care.

_______ I understand that my required co-pay is due at the time of service.

_______ I understand that if I have any balances, I will set up a payment plan and remain current.

_______ I understand that if I become eligible for insurance I will inform the Business Office and the PFA benefits will no longer be in effect.

I, ______________________________ attest that the information provided in this application is true and correct.

I authorize West Georgia Cardiology representatives to obtain my financial information from the Internal Revenue Service, Department of Labor, the Social Security Administration, the Division of Family and Children Services and/or any other agency as necessary to determine my ability to provide payment. I also authorize them to access my credit history from the credit bureau if deemed necessary.

Applicant Signature: ______________________ Date: ______________

FOR OFFICE USE ONLY:

Total yearly gross: $____________
Meets PFA guidelines: ☐
Eligible percentage? ____________%

Does not meet PFA guidelines: ☐
Reason: ______________________________