MUSC Health
Medical University of South Carolina

MUSC Health Application for Financial Assistance

Applicant Name *(First, Middle, Last)*	Service Dates	Medical Record Number

Instructions: Complete application and attach copies (no originals) of:

- ***Valid Forms of ID (Driver's License, State I.D. card, Passport, etc.)***
- ***Tax returns and supporting schedules (previous year)***
- ***Social Security/Disability, W-2 or Unemployment (if applicable)***
- ***Pay Stubs (Most recent month)***

Are you a South Carolina resident? ☐ **Yes** ☐ **No** If no, (list state)_____

Service Location(s)

- Charleston University Medical Center ☐
- Chester Medical Center ☐
- Florence Medical Center ☐
- Lancaster Medical Center ☐
- Marion Medical Center ☐
- Kershaw Medical Center ☐
- Columbia Medical Center (Downtown/Northeast) ☐
- Black River Medical Center ☐
- Orangeburg Medical Center ☐

Patient/Responsible Party

Name *(First, Middle, Last)*		Social Security Number	Birth Date *(Month DD, YYYY)*
Address		City	State / ZIP Code
Phone	Household Size (Patient, Spouse and Dependents)		Marital Status
Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student			Employer Name & Address
Employment Length	Unemployed Date/Length *(Month DD, YYYY)*		Are you claimed on another tax return? ☐ Yes ☐ No (If yes provide tax returns of those being claimed)

Spouse/Partner

Name *(First, Middle, Last)*		Social Security Number	Birth Date *(Month DD, YYYY)*
Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student			Employer Name & Address
Employment Length	Unemployed Date/Length *(Month DD, YYYY)*		

Dependents (If more than 3 dependents use separate page)

Full Name	Relationship	Birth Date *(Month DD, YYYY)*
1.		
2.		
3.		

Certification

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by MUSC or an affiliated entity and I give permission to MUSC and all affiliated clinics, hospitals and entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to MUSC, all MUSC affiliates and representatives or agents to investigate the information contained herein, and to approve my application.

Patient/Responsible Party Signature	Date *(Month DD, YYYY)*

Please mail this completed form with required documentation to the following address:

ATTN: MEDICAL UNIVERISTY OF SOUTH CAROLINA
1 Poston Road, Suite 300
Charleston, SC 29407
843-792-2311

In 4 to 6 weeks, you will receive correspondence to inform you if you are eligible for financial assistance. If you receive an approval letter, it does not guarantee that all services at MUSC are approved or that future services will be approved for financial assistance. Please call the MUSC Customer Service Team at 843-792-2311 for any questions, comments or concerns.

You may also apply online at https://mychart.musc.edu