Summit Radiology Services
P.O. Box 200096
Cartersville, GA 30120

Ph 770-607-7339 Fx 770-607-0789

Dear Applicant,

Financial Assistance for Summit Radiology Services bills is available to those who qualify with proper documentation for bills over $100 (one hundred dollars). Summit Radiology Services bills separately as stated at each location.

If you need financial assistance please fill out the form COMPLETELY. Incomplete forms will NOT be processed. Please submit copies of all required documents for the application to be considered. (Do NOT mail originals as they will not be returned to you).

Your application MUST also include the following:

- Paycheck stubs for the past 3 months and/or Social Security check stubs
- Last filed Federal and State income tax returns
- Last W-2
- Bank statements for the past 3 months
- Letter explaining current hardship
- Itemized list of expenses

The application must be mailed to the address on the form. Incomplete applications and/or applications missing required documents will not be considered and the file will be closed with no further review. You may reapply one time with a completed application and all documentation.

You may send the application via certified mail if you would like proof of delivery. To find out if you are approved for financial assistance, you will need to call our office at 770-607-7339 thirty (30) days after mailing the application. (Please do not call until 30 days has passed as it takes a minimum of four weeks to process.)

Thank you,
Summit Radiology Services

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Patient Name: _____ SS#: _____

Responsible Party Name: _____ SS#: _____

Account #: _____ Facility Name: _____

Employment (patient/Responsible party)

Employer Name: _____

Weekly Gross Amount: _____

Employment (Spouse)

Employer Name: _____

Weekly Gross Amount: _____

Dependents (Include spouse and all children under 18)

Name	Age	Relationship to patient

List other income:

Social Security: _____

Unemployment (weekly): _____

Child Support/Alimony: _____

Pension/Retirement: _____

Other: _____

Have you applied for Medicaid or other assistance? If yes, please explain:

I, undersigned, certify that the information provided on this application is true and accurate to the best of my knowledge. I understand that this information is subject to verification and that this submission does not guarantee approval of assistance. I further understand that this provides authorization to run a credit report if necessary.

Signature: _____ Date: _____