Completion of the following questions are necessary to evaluate patient eligibility

Date of Application:\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Account Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information: Spouse Information (if applicable):**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status** (circle one): Married Single Divorced Widowed Unmarried Partnered

**Health Coverage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family information:** Please list all dependents living in the home (children under 21 years of age):

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Age** | **Relationship** |
| **1.** |  |  |  |
| **2.** |  |  |  |
| **3.** |  |  |  |
| **4.** |  |  |  |
| **5.** |  |  |  |
| **6.** |  |  |  |

|  |  |
| --- | --- |
| **Total No. of Dependents** |  |

**Income Information:**

|  |  |  |
| --- | --- | --- |
| **Income** | **Patient** | **Spouse** |
| Wages (gross monthly income) |  |  |
| Self-Employed (gross monthly income) |  |  |

**Other Income:**

|  |  |  |
| --- | --- | --- |
| **Income:** | **Patient** | **Spouse** |
| Disability |  |  |
| Social Security |  |  |
| Unemployment Comp |  |  |
| **Income:** | **Patient** | **Spouse** |
| Public Assistance |  |  |
| Workman’s Comp |  |  |
| Alimony |  |  |
| Child Support |  |  |
| Pension Income |  |  |
| Income from Dividends, Interest, Rent |  |  |
| Other |  |  |
| **Total Income** |  |  |

|  |  |
| --- | --- |
| **Combined Income** |  |

**Expenses Information:**

|  |  |  |
| --- | --- | --- |
|  | **Description** | **Amount** (monthly payment) |
| 1. | Mortgage/Rent |  |
| 2. | Car Payment |  |
| 3. | Auto Insurance |  |
| 4. | Mortgage/Rent (maintenance) |  |
| 5. | Food & household supplies |  |
| 6. | Utilities |  |
| 7. | Telephone |  |
| 8. | Clothing |  |
| 9. | Medical & Dental payments |  |
| 10. | Insurance |  |
| 11. | School/Child Care |  |
| 12. | Child or Spousal support |  |
| 13. | Transportation/Auto expenses (insurance, gas |  |
| 14. | Other |  |
|  | **TOTAL MONTHLY EXPENSES** |  |

**Required Documents**

The following Documents must be attached to process your application for Charity Care/Financial Assistance/Discount:

**Proof of Income:** Prior Year income tax return OR most recent check stub’s (one month), letter from employer, Social Security, etc. or other documents as requested.

**Proof of Expenses** (if applicable)**:** Copy of Mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones), or other documents as requested.

**Hardship Letter** (if applicable)**:** A letter explaining why you are unable to pay your account in full or with a payment agreement.

**I hereby acknowledge that all of the information provided above is true and correct. I understand that providing false information will result in the denial of this Application. I authorize you to obtain a consumer credit report on me as well as reports from other national databases, to verify information provided in this Application. I fully understand that Financial Assistance program is a “Payer of Last Resort” and hereby assign to the facility all benefits due from any liability action, personal injury claims, settlements and any and all insurance benefits which may become payable, for illness or injury for which the facility has provided care.**

**PATIENT/GUARANTOR PRINTED NAME DATE**

**PATIENT/GUARANTOR SIGNATURE DATE**

**HOSPITAL REPRESENTATIVE COMPLETING APPLICATION DATE**

**FOR INTERNAL USE ONLY:**

**Estimate Charges:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% of discount to be given\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approved\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_ Valid Through\_\_\_\_\_\_\_\_**

**Denied\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Income exceeds Charity Care threshold**

**Patient did not comply with documentation needed**

**Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**