DISCOUNT and CHARITY CARE ELIGIBILITY APPLICATION

Completion of the following questions are necessary to evaluate patient eligibility

Date of Application:_____________

Patient Account Number(s): ____

____

Patient Information:

Name:________________________________

Address:______________________________

____

Phone:_______________________________

SSN:_________________________________

Spouse Information (if applicable):

Name:________________________________

Address:______________________________

____

Phone:_______________________________

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		

DISCOUNT and CHARITY CARE ELIGIBILITY APPLICATION

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.

DISCOUNT and CHARITY CARE ELIGIBILITY APPLICATION

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:____**