

Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name:	SSN:	DOB:
Patient Address:				
Patient Home Phone:			Patient Work Phone:	

SECTION A

MEDICAL ASSISTANCE SCREENING—Please check answer “Y” for yes to “N” for no.

- | | |
|---|---|
| <p>1. Is the patient under age 21 or over age 65? Y / N
<input type="checkbox"/> / <input type="checkbox"/></p> <p>2. Is the patient a single parent of a child under age 21? <input type="checkbox"/> / <input type="checkbox"/></p> <p>3. Is the patient a caretaker or guardian of a child under 21? <input type="checkbox"/> / <input type="checkbox"/></p> <p>4. Is the patient a married parent of a minor child? <input type="checkbox"/> / <input type="checkbox"/>
<i>If yes, does the patient have a 30-day incapacitation?</i></p> | <p>5. Is the patient pregnant, or was the admission pregnancy related? Y / N
<input type="checkbox"/> / <input type="checkbox"/></p> <p>6. Will the patient potentially be disabled for 12 months? <input type="checkbox"/> / <input type="checkbox"/></p> <p>7. Is the patient a Victim of Crime? <input type="checkbox"/> / <input type="checkbox"/></p> <p>8. Does the patient have a “COBRA” or insurance policy that the premium has lapsed? <input type="checkbox"/> / <input type="checkbox"/></p> |
|---|---|

SECTION B

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient:	
SSN:	DOB:		
Home Address:			Phone #:
Work Address:			Phone #:
Gross Income: \$	Circle One - <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		
Hours Per Week:			
If income is \$0/unemployed, what is your means of support?	<input type="checkbox"/> Living on Savings/Annuity <input type="checkbox"/> Live with parent/familv/friends Homeless <input type="checkbox"/> Shelter <input type="checkbox"/> Deceased <input type="checkbox"/> Other: _____		

SPOUSE

Responsibility Party:			
SSN:	DOB:		
Home Address:			Phone #:
Work Address:			Phone #:
Gross Income: \$	Circle One - <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		
Hours Per Week:			

SECTION C

HOMELESS AFFIDAVIT

I, hereby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others. Patient/Guarantor Initials _____

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in the denial of this Application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Riverside University Health System Charity Care program(s) is a “Payor of Last Resort” and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which Riverside University Health System or its' subsidiaries provided care.

PATIENT/GUARANTOR SIGNATURE

DATE

List **ALL PERSONS LIVING IN THE HOUSE YOU ARE LIVING IN** (Including yourself, spouse, significant other & all dependants)

<u>First and Last Name</u>	<u>Social Security Number (If known)</u>	<u>Sex</u>	<u>Birth Date</u>	<u>Relationship</u>
1. _____	_____	M/F	_____	_____
2. _____	_____	M/F	_____	_____
3. _____	_____	M/F	_____	_____
4. _____	_____	M/F	_____	_____
5. _____	_____	M/F	_____	_____
6. _____	_____	M/F	_____	_____
7. _____	_____	M/F	_____	_____
8. _____	_____	M/F	_____	_____
9. _____	_____	M/F	_____	_____

Are you, your spouse, significant other or your dependants working? Yes No

Person Working	How often do you get paid?	Hours worked a week	Number of days worked a week	Gross income per month
1)				
2)				

Company's Name	Company's Address
1)	
2)	

Date you, your spouse/significant other were hired? _____

When was the last time you filed income taxes? _____

Are you, your spouse, significant other or your dependants self employed? Yes No

Person Working	Type of Business	Home Business? Yes [] No []	Estimated monthly income after business expenses
1)		Yes [] No []	
2)		Yes [] No []	
Name of your Business	Address of your Business		