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***[Hospital/system name/logo]***

**Charity Care/Financial Assistance Application Form – confidential**

*Please fill out all information completely. If it does not apply, write “NA.” Attach additional pages if needed.*

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| **SCREENING INFORMATION** |
| Do you need an interpreter? **□ Yes □ No** *If Yes, list preferred language:* |
| Has the patient applied for Medicaid? **□ Yes □ No** |
| Does the patient receive state public services such as TANF, Basic Food, or WIC? **□ Yes □ No** |
| Is the patient currently homeless? **□ Yes □ No** |
| Is the patient’s medical care need related to a car accident or work injury?**□ Yes □ No** |
| **PLEASE NOTE** |
| * We cannot guarantee that you will qualify for financial assistance, even if you apply. * Once you send in your application, we may check all the information and may ask for additional information or proof of income. * Within 21 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance. |

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| **PATIENT AND APPLICANT INFORMATION** | | | |
| Patient first name | Patient middle name | | Patient last name |
| □ Male □ Female  □ Other (may specify \_\_\_\_\_\_\_\_\_\_\_\_\_) | Birth Date | | Patient Social Security Number (optional) |
| Person Responsible for Paying Bill | Relationship to Patient | Birth Date | Social Security Number (optional) |
| Mailing Address  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City State Zip Code | | | Main contact number(s)  ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email Address:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employment status of person responsible for paying bill  □ **Employed** (date of hire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) □ **Unemployed** (how long unemployed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  □ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | | | |

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| **FAMILY INFORMATION** | | | | | |
| Household means: a single individual; or spouses, domestic partners, or a parent and child under 18 years of age, living together; and other individuals for whom a single individual, spouse, domestic partner or parent is financially responsible.  **FAMILY SIZE \_\_\_\_\_\_\_\_\_\_\_** *Attach additional page if needed* | | | | | |
| Name | Date of Birth | Relationship to Patient | If 18 years old or older:  Employer(s) name or source of income | If 18 years old or older:  Total gross monthly income (before taxes): | Also applying for financial assistance? |
|  |  |  |  |  | Yes / No |
|  |  |  |  |  | Yes / No |
|  |  |  |  |  | Yes / No |
|  |  |  |  |  | Yes / No |
| **All adult family members’ income must be disclosed. Sources of income include, for example:**  - Wages - Unemployment - Self-employment - Worker’s compensation - Disability - SSI - Child/spousal support  - Work study programs (students) - Pension - Retirement account distributions - Other (*please explain\_\_\_\_\_\_\_\_\_\_\_\_\_)* | | | | | |

***[Hospital/system name/logo]***

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| **INCOME INFORMATION** |
| ***REMEMBER****: You must include proof of income with your application.* |
| **You must provide information on your family’s income. Income verification is required to determine financial assistance.**  **All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.**  **Examples of proof of income include:**   * A "W-2" withholding statement; or * Current pay stubs (*3 months*); or * Last year’s income tax return, including schedules if applicable; or * Written, signed statements from employers or others; or * Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or * Approval/denial of eligibility for unemployment compensation.   If you have no proof of income or no income, please attach an additional page with an explanation. |

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| **EXPENSE INFORMATION** |
| *(This section is optional and may be used to determine eligibility for other assistance programs)* |
| Monthly Household Expenses:  Rent/mortgage $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical expenses $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Premiums $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Utilities $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Debt/Expenses $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*child support, loans, medications, other*) |

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| **ASSET INFORMATION** | |
| *(This section is optional and may be used to determine eligibility for other assistance programs)* | |
| Current checking account balance  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current savings account balance  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Does your family have these other assets?  **Please check all that apply**  □ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)  □ Property (excluding primary residence) □ Own a business |

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| **ADDITIONAL INFORMATION** |
| Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss. |

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| **PATIENT AGREEMENT** |
| I understand that [*Hospital/system Name]* may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.  I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Person Applying Date |