Confidential Financial Assistance Application

Patient Information

Facility:_____Pat Acct #:_____

Patient Name:_____

SSN:_____Birth Date:_____

Home Phone:_____Work Phone:_____

Patient Address:_____

MEDICAL ASSISTANCE SCREENING - Please circle answer "Y" for yes or "N" for no.

1. Is the patient under age 18 or over age 65?	Y / N
2. Is the patient a single parent of a child under age 18?	Y / N
3. Is the patient a caretaker or guardian of a child under age 18?	Y / N
4. Is the patient a married parent of a minor child?	Y / N
If yes, does the patient have a 30-day incapacitation?	Y / N
5. Is the patient pregnant or was the admission pregnancy related?	Y / N
6. Will the patient potentially be disabled for 12 months?	Y / N
7. Is the patient victim of crime?	Y / N
8. Does the patient have a COBRA or insurance policy per which the premium lapse?	Y / N

Total number of dependent family members in the household:____

(Include patient, patient's spouse and/or legal guardian and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income: $____

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

Responsible Party/Guarantor Information

Name:_____Relationship to Patient:_____

SSN:_____Birth Date:_____

Home Phone:_____Work Phone:_____

Home Address:_____

Work Address:_____

Gross Income:_____Check one: Hours per Week:____

Hourly__Daily__Weekly__Bi-Weekly__Monthly__Yearly__

If income is $0/unemployed, what is your means of support?

__Live on Savings/Annuities __Homeless__Shelter__Deceased

__Live with parent/family/friend Other_____

Spouse Information

Name:_____Relationship to Patient:_____

SSN:_____Birth Date:_____

Home Phone:_____Work Phone:_____

Home Address:_____

Work Address:_____

Gross Income:_____Check one: Hours per Week:____

Hourly Daily Weekly Bi-Weekly Monthly Yearly

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, CONSUMER CREDIT REPORT AUTHORIZATION, AND ASSIGNMENT OF BENEFITS

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 fully understand that Financial Assistance Center programs are a "Payor 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 or its subsidiaries provided care.

PLEASE NOTE: This application form is used to determine your eligibility for both charity care and discounted payment under the hospital's policies. If you are eligible for discounted payment, then the financial assistance you receive will be lower than if you qualify for charity care. The only forms of documentation that you are required to provide to prove household income are recent pay stubs or income tax returns—we may accept other forms of documentation but do not require it.

_____

PATIENT/GUARANTOR PRINTED NAME

_____ _____

PATIENT/GUARANTOR SIGNATURE DATE