| For Hospital Use Only: | |
|---|---|
| Pt Name: | |
| Account #: | |
| Date Mailed/Given to Pt: | |
| By Whom: | |
| Dept: | |


# Medicare Charity Care Application

Nathan Littauer Hospital is committed to providing medical care to those patients who may not have sufficient financial resources to meet their medical care needs. To apply for Charity Care for your hospital account(s), **The Charity Care Applicaton must be completed fully, signed and returned to the hospital** Please return all supporting documents with the application.

Upon review of the application, further information may be requested of you. Any potential source of payment, including state and federal assistance programs, all insurance sources, and legal settlements, must be exhausted before forgiveness of account balances will be considered. Your application for assistance will be given equal consideration in a non-discriminatory manner. **Please understand that this application is for consideration of the Hospital charges only and DOES NOT cover billing from your private physician, radiologist, emergency room physician, consulting physician, hospital retail pharmacy or any other services not provided by the hospital.**

For questions or to inquire about the status of your application, please call **518-773-5551**

| | | |
|---|---|---|
| Patient Name (Last, First,MI) | | |
| Social Security # | Date of Birth | |
| Address | Mailing Address (If different than residence) | |
| County of residence | Home phone | |
| Employer | Phone | How long? |
| Previous Employer | Phone | How long? |
| Employer/Spouse | Phone | |

**Insurance**

If you have medical insurance, please provide that information below. Also, if your hospitalization is the result of an injury or accident, please provide us with the necessary Auto/Homeowner's, Workers Compensation or Third Party insurance below:

| | | | |
|---|---|---|---|
| Insurance Co. | | Policy # | |
| Address | | Phone# | |
| City/State/Zip | | Insured | SSN# |
| Attorney Name/Address/Phone# | | | |
| Nature of Injury or Accident | | Police Report# | |

**Household Members And Income Information**

Please list all household members and include all sources of income for each household member, including non-employment sources, such as Worker's Compensation, Unemployment Compensation, pensions, rental income, interest from investments, dividends, trust funds, child support, alimony, income from Social Security, Veterans Administration or other benefit program.

| **Family Members** | | | **Monthly Gross Income** | |
|---|---|---|---|---|
| Self | | | $ | Source |
| Husband/Father | SSN | | $ | Source |
| Wife/Mother | SSN | | $ | Source |
| Dependant Children | | | $ | Source |
| Name | | Date of Birth | | |
| Name | | Date of Birth | | |
| Name | | Date of Birth | | |
| Other children | | | | |
| Name | | Date of Birth | | |
| Name | | Date of Birth | | |
| Name | | Date of Birth | | |
| **Total Family Members** | | | | |

| **Total Monthly Gross Income** |
|---|
| $ |

## Medicare Charity Care Application

| Bank Name | Checking Acct # | Avg Bal. | Saving Acct. # | Avg Bal. |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Assets** **Total**

Vehicles Make _____ Model _____ Year _____ Pmt. Amt. _____ Bal Due _____

Make _____ Model _____ Year _____ Pmt. Amt. _____ Bal Due _____

Other Assets (Stocks, Bonds,Property,Boat, Buisiness etc.)

**Monthly Expenses**

| | Monthly Payment | Payment To | Acct. # | Bal Due |
|---|---|---|---|---|
| Mortgage/Rent | | | | |
| Credit Cards | | | | |
| | | | | |
| | | | | |
| | | | | |
| Bank Loans | | | | |
| School Loans | | | | |
| Other Monthly Expenses | | | | |
| | | | | |
| | | | | |
| | | | | |

Note: Attach additional sheet if necessary. **Important: remember to attach supporting documentation.**

## Medicare Charity Care Application

**Have you filed for any state or federal assistance during the past year?** Date of application: _____

Medicaid ☐ Y / N ☐ Social Security Disability ☐ Y / N ☐ Victims Compensation ☐ Y / N ☐

Please list any recent accounts that you or your immediate family members may have at Nathan Littauer Hospital or one of our Primary Care sites.

| **Patient Name** | **Account #** | **Date of Service** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

I certify that the above information is true and accurate to the best of my knowledge. I have read and agree to comply with all terms and requirements set forth in the notice of availability of Charity Care.

Signature of applicant: _____

Date: _____

**For Hospital Use Only:** Referred to DSS ( ) SSI ( ) Victim's Comp ( ) Other _____

| Acct Number | Reviewed | Approved | Denied | |
|---|---|---|---|---|
| | ( ) | ( ) | ( ) | |
| | ( ) | ( ) | ( ) | |
| | ( ) | ( ) | ( ) | |
| | ( ) | ( ) | ( ) | |
| | ( ) | ( ) | ( ) | |
| | ( ) | ( ) | ( ) | |

_____

Patient/Parent/Guardian Signature Date

Print Form