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

Charity Care Application - Short Form

Dear Patient:

We ask that you complete the form below and return it to Patient Accounts-Charity Care Office. We will review the information and determine if you are eligible for our charity care program.

Patient Name _____

Social Security # _____

City/State/Zip _____

Phone # _____

County of residence _____

# of Dependents under 18 years _____

Marital Status (please check one):
- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Divorced
- ☐ Single

* Current Monthly Household Income _____

Total Yearly Household Income _____

Employer Name _____

Have you filed for any state or federal assistance during the past year?

Date of application _____

Medicaid ☐ Y / N☐ Social Security Disability ☐Y / N☐ Victim's Compensation ☐ Y / N☐

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

* May require verification

Print Form