Charity Care Application

Client Name: _____ **Date:** _____

Address: _____ **Date of Birth:** _____

_____ **Social Security Number:** _____

Phone Number: _____ **Work Phone:** _____

Total Number of Dependents: _____

List your household members, including yourself, spouse, children, and any person you claim as a dependent:

Name	Date of Birth	Relationship

Are any of the above individuals eligible for or receiving government assistance (ie., Medicaid, Medicare, Food Stamps)? ☐ Yes ☐ No

If yes, describe: _____

Name	Annual Gross Income
	$
	$
Total	$

***** Proof of income must be verified by copy of 2 pay stubs or tax return. *****

Applicant must initial next to each of the following statements to indicate understanding.

	My initials indicate that all income amounts are accurate, including those being reported as "zero income".
	I understand that providing false information may result in my being financially responsible for 100% of billable charges.
	I understand that I must renew this application every 6 months or sooner if my financial situation changes (ie., income, number of dependents).

I certify that the family size and income information shown above is correct. I understand that copies of tax returns, pay stubs, or other information verifying income is required before charity care will be approved.

_____ _____

Signature of Client/Parent/Guardian Date Witness Signature Date

Financial Interview Worksheet

Monthly Income	Amount	Monthly Expenses	Amount
Salary / Wages		**Housing**	
Client salary / wages earned	$	Rent / Mortgage	$
Spouse salary / wages earned	$	Taxes / Insurance	$
Other household income	$	Utilities	$
Unemployment benefits	$	Telephone / Cell phone	$
		Maintenance	$
Investment Income			
Interest earned	$	**Personal**	
Dividends received	$	Groceries / Other meals	$
Rental property income	$	Grooming / toiletries	$
Other	$	Clothing	$
		Insurance	$
Other Income		Child care / support	$
Social Security (Retirement / Disability)	$	School	$
Pension benefits	$		
Child support	$	**Transportation**	
		Automobile loan / Insurance	$
Total Monthly Income	$	Gasoline	$
		Public transportation	$
		Other	
		Credit cards	$
		Medical / Prescription	$
		Loans	$
		Total Monthly Expenses	$
Monthly Surplus / Deficit: $			

Client eligible for: ☐ On- going charity care ☐ One-time Write-off ☐ No Assistance

Reason for no assistance:

Date for re-evaluation of financial status *(6 months from date of application)*: _____

County Director Date

Senior Vice President of Finance Date
(If over $1,000)

Business Operation Director Date

President / CEO Date
(If over $5,000)

Client Name: _____
MRN: _____
Location: _____