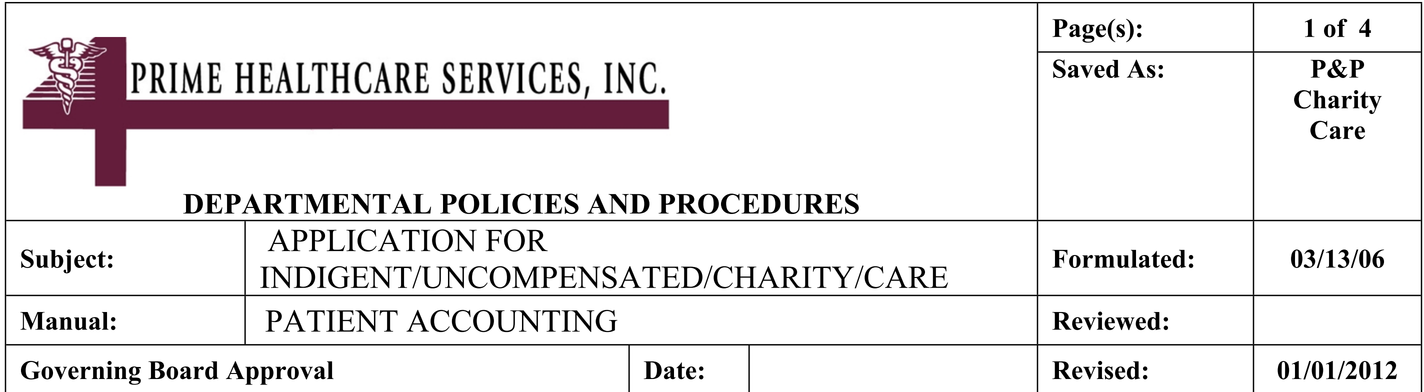

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PRIME HEALTHCARE SERVICES, INC. DEPARTMENTAL POLICIES AND PROCEDURES				Saved As:	P&P Charity Care
Subject:	APPLICATION FOR INDIGENT/UNCOMPENSATED/CHARITY/CARE			**Formulated:**	**03/13/06**
Manual:	PATIENT ACCOUNTING			**Reviewed:**	
Governing Board Approval		**Date:**		**Revised:**	**01/01/2012**

Application for Uncompensated Care/Charity/Indigent Care
To be Completed by Financial Responsible Party

Please complete this application in its entirety.

Account Number: ___________

Date:_________________

Name:______________________

Patient Name:_____________________

Patients Employer:___________________

Patient Address:_________________________

City / State:____________________________

Phone Number:__________________

Date Of Birth:______________

Social Security Number_______________

Guarantor Name:_____________________________

Guarantor Employer__________________

Guarantor Address:___________________ Phone Number:_______________

Guarantor Social Security Number_______________

As provided for in Federal Law, I hereby request that PRIME HEALTHCARE SERVICES make a determination of my eligibility for uncompensated services. I understand that the information that I submit concerning my annual income and family size is subject to verification by the hospital. I also understand that if the information is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

Please fill out the following:	**Total for last 12 months**
Wages:	$_______________
Social Security	$_________________
Strike Benefits	$_________________
Alimony/Child Support	$_________________
Military Allotment	$_________________
Dividends/Interest	$_________________
Pensions	$_________________
Unemployment	$_________________
Disability	$_________________
IRA	$_________________
Trust Account	$_________________
Interest Income	$_________________
Other	$_________________

Proof of income attached: { } W-2 Form { } Pay check stubs { } Tax Return

Expenses:

House/Rent Payment $____________

Food:$________

Water:$_______

Gas & Electricity:$___________

Trash:$_________

Child Support:$_________

Auto Expenses:$____________

Insurance:$____________

Credit Cards:

Company:_______________ Balance Owing:$__________

Amount Available:$_________

Company________________ Balance Owing:$__________

Amount Available:$_________

Company________________ Balance Owing:$__________

Amount Available:$__________

Medical Bills:

Hospital/Doctor Names________________________________

Amount:$________________

Number of family members in household:__________

Name:____________________ Relationship__________

Name:____________________ Relationship:__________

Name:____________________ Relationship:__________

Bank References:

Checking: Name/Branch:__________________ Account # ___________

Savings: Name/Branch____________________ Account # ___________

Assets:

Do you own your own Home?______ Value:__________

Do you own other property? _______ Value:__________

Do you own your own automobiles? ______ Value__________

I agree that my physician may be informed of the status of this application for uncompensated care.

I understand that I may be asked to prove my statements and that my eligibility statement will be subject to verification by contact with my employer, bank, credit verification and property searches.

I affirm that the statements made herein are true and correct to the best of my knowledge.

Signature of applicant: ______________________ **Date:**____________

Witness:________________________ **Date:**__________