Exhibit C
Example of Financial Assistance Form

_____ Regional Medical Center
Charity Care/Financial Assistance Program Application

Patient Account Number:_____ Date of Application_____

PATIENT INFORMATION	PARENT/GUARANTOR/SPOUSE
Name_____	Name_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
SS#_____	SS#_____
Employer_____	Employer_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
Work Phone_____	Work Phone_____
Length of Employment_____	Length of Employment_____
Supervisor_____	Supervisor_____

RESOURCES

Checking: yes___ no___
Savings: yes___ no___

Cash on hand: $_____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Exhibit C (continued)
Charity Care/Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other(explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

Proof of Income: Prior year income tax return, last 4 pay check stubs, letter from employer, Social Security, etc. Last 3 months bank statements. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Hospital Representative Completing Application: _____

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The below signatures is indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.

Approval/Authorization of Charity Write-Off **Amount Approved $_____**

BOM_____ **CEO_____**
CFO_____

Exhibit D

Income Guidelines For Determining % of Charity Care Discount
(For Financially Indigent Patients)

Based Current Year's Federal Poverty Income Guidelines

% of Poverty Income	Discount from Gross Charges
100-150%	100%
150-200%	90%
200-250%	80%
250-300%	75%
300-350%	50%

Exhibit E

2008 Federal Poverty Income Guideline

The Department of Health and Human Services has issued updated Poverty Guidelines for 2008 (reference: Federal Register: January 23, 2008, Volume 73, Number 15 pp. 3971-3972).

2008 HHS Poverty Guidelines

Persons in Family	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,400	$13,000	$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

These guidelines are effective immediately upon publication in the Federal Register. As noted In the Federal Register notice, there is no universal administrative definition of income that is valid for all programs that use the poverty guidelines. The office or organization that administers a particular program or activity is responsible for making decisions about the definition of income used by that program…to find out the specific definition of income used by a particular program, you must consult the office or organization that administers that program.