

REVENUE CYCLE PROCEDURE	Effective Date Jan 1, 2007
PATIENT ACCESS	Page:11
HOSPITAL POLICY	Original Date: 06/01/06
CHARITY CARE AND SELFPAY DISCOUNT POLICY	Revised Date: 05/22/2011

Exhibit B - Confidential Financial Application

AHMC Confidential Medical and Financial Assistance Application

Facility: ARMC	Acct. #:	Patient Nam	ne:		SSN:	DC	B:
Patient Address:	-						=-
Patient Home Phor	ne:		Pa	atient Work Phone:	None		
						on the car	
CECTION A							
SECTION A MEDICAL ASSIST	ANCE SCREENING- Please			yes to "N" for no.			
4 1-41		Y	/ N				Y / N
	t under age 21 or over age		1		ent pregnant, or was the pregnancy related?		1
21?	t a single parent of a child u		1	6 Will the pa	atient potentially be dis	abled for	1
Is the patient inder 21?	a caretaker or guardian of a	a child	1	7. Is the patie	ent a Victim of Crime?		1
. Is the patient a	a married parent of a minor	child2	1	-	# #00DDA#	inquironos	- 1
			,		tient have a "COBRA" or he premium has lapsed?	insurance	
	is the patient have a 30-day in				tient have a "COBRA" or he premium has lapsed?	Insurance	
SECTION B n order to deter	s the patient have a 30-day in	capacitation?	-	policy that t	he premium has lapsed?		is necessary
If yes, doe SECTION B n order to deter ESPONSIBLE PA	s the patient have a 30-day in rmine qualifications for ARTY/GUARANTOR	capacitation?	-	policy that t	he premium has lapsed?		is necessary
If yes, doe SECTION B order to deter ESPONSIBLE PA Responsibility Par	s the patient have a 30-day in rmine qualifications for ARTY/GUARANTOR	capacitation?	-	policy that t	he premium has lapsed?		is necessary
If yes, doe SECTION B n order to deter ESPONSIBLE PA Responsibility Par SSN:	s the patient have a 30-day in rmine qualifications for ARTY/GUARANTOR	capacitation?	-	policy that t	he premium has lapsed?	nformation	is necessary
If yes, doe SECTION B n order to deter ESPONSIBLE PA Responsibility Par SSN: Home Address:	s the patient have a 30-day in rmine qualifications for ARTY/GUARANTOR	capacitation?	-	policy that t	he premium has lapsed?	nformation	
If yes, doe SECTION B n order to deter RESPONSIBLE PA Responsibility Par SSN: Home Address: Work Address:	s the patient have a 30-day in rmine qualifications for ARTY/GUARANTOR	any discounts DOB:	s or as	policy that t	he premium has lapsed?	nformation	#:
If yes, doe SECTION B n order to deter ESPONSIBLE PA Responsibility Par SSN: Home Address: Work Address:	s the patient have a 30-day in rmine qualifications for ARTY/GUARANTOR	any discounts DOB: Circle One - [s or as	policy that t	he premium has lapsed?	ip to patient: Phone Phone	#: #:
If yes, doe SECTION B n order to deter ESPONSIBLE PA Responsibility Par SSN: Home Address: Work Address: Gross Income:	rmine qualifications for ARTY/GUARANTOR rty:	any discounts DOB: Circle One - [Hours Per We	s or as	policy that the ssistance programme	he premium has lapsed? ams the following ir Relationsh eekly Bi-Weekly	ip to patient: Phone Phone Monthly	#: #: Yearly
If yes, doe SECTION B n order to deter RESPONSIBLE PA Responsibility Par SSN: Home Address: Work Address: Gross Income:	rmine qualifications for ARTY/GUARANTOR rty:	any discounts DOB: Circle One - [Hours Per We	s or as	policy that the ssistance programme	he premium has lapsed? ams the following ir Relationsh	ip to patient: Phone Phone Monthly	#: #: Yearly
If yes, doe SECTION B n order to deter ESPONSIBLE PA Responsibility Par SSN: Home Address: Work Address: Gross Income: If income is \$0/under means of support	rmine qualifications for ARTY/GUARANTOR rty:	any discounts DOB: Circle One - [Hours Per We	Housek:	policy that the ssistance programs and the sistance programs are sistance programs. The sistance programs are sistance programs are sistance programs. The sistance programs are sistance programs are sistance programs. The sistance programs are sistance programs are sistance programs are sistance programs. The sistance programs are sistance programs are sistance programs are sistance programs.	he premium has lapsed? ams the following in Relationsh deekly Bi-Weekly with parent/family/frier	ip to patient: Phone Phone Monthly	#: #: Yearly
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SECTION C

		IDAVIT

I, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others.

Patient/Guarantor Initials

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in the denial of this Application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services maybe considered an unlawful act. I also acknowledge and n(s) is a "Payor rance benefits

consent that a credit report may be obtained or other such measure may of Last Resort" and hereby confirm all prior assignments of benefits and which may become payable, for fitness or injury, for which AHMC or its's	be taken to verify information provided herein. I fully understand that AHMC Charity Care program(s) is a "lifty rights, which may include liability actions, personal injury claims, settlements, and any and all insurance be subsidiaries provided care.
PATIENT/GUARANTOR SIGNATURE	DATE
	SECTION D
FINANCIAL ASSISTANCE SCREENING Total Number of Dependent Family Members in (Include patient, patient's spouse and/legal gual home. If the patient is a minor, include mother/fa living in the home.)	Household <u>1</u> ardian, and any children the patient has under the age of 18 living in the ather and/or legal guardian, and all other children under the age of 18
Estimated Gross Annual Household Income \$ 0.	.00_
Calculate Income to FPG Ratio: \$ Gross Annual Income ÷ FPG Based on Family S	Size %
or and an analysis	70
Type of Service Check One	ER OP IP MULTI
Total Co-pay Amount Due: \$	

SECTION E

OFFICE USE ONLY

Family Size:	1	Acct Number(s) / Branch	Pt Type / Date of Service	Balance	W/O Amount	Co-Pay
Gross Annual Family Income:	\$				\$	\$
FPG based on Family Size:	\$					\$
Current Hospital Charges (w/ in 6 months):	\$			\$	\$	\$
Income/FPG:	%			\$	\$	\$
Income X 2:	\$			\$	\$	\$
Total Hospital Charges:	\$		1	L		



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Prepared by	Date	Unit	
Examined by	Date	Unit	
Approved or Denied by	Date	Title	
Denial Reason:			