B. Attachment 2 – Confidential Financial Application

Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name:	SSN:	DOB:
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

SECTION A

MEDICAL ASSISTANCE SCREENING – *Please circle answer "Y" for yes or "N" for no.*

1. Is the patient under age 21 or over age 65? Y / N
2. Is the patient a single parent of a child under age 21? Y / N
3. Is the patient a caretaker or guardian of a child under 21? Y / N
4. Is the patient a married parent of a minor child? *If yes, does the patient have a 30-day incapacitation?* Y / N
5. Is the patient pregnant, or was the admission pregnancy-related? Y / N
6. Will the patient potentially be disabled for 12 months? Y / N
7. Is the patient a Victim of Crime? Y / N
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? Y / N

SECTION B

FINANCIAL ASSISTANCE SCREENING

Total Number of Dependent Family Members in Household _____

(Include patient, patient's spouse and/or legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father, Caretaker, and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $_____ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size

_____ ÷ _____ = _____%

Type of Service (circle one) ER OP IP

Service Date _____ to _____

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:			Relationship to patient:
SSN:	DOB:		
Home Address:			Phone #:
Work Address:			Phone #:
Gross Income:	Check One: Hourly Daily Weekly Monthly Yearly		
	Hours Per Week:		
If income is $0/unemployed, what is your means of support?	Check One: Living on Savings/Annuity Live with parent/family/friends Homeless Shelter		

SPOUSE

Responsibility Party:			
SSN:	DOB:		
Home Address:			Phone #:
Work Address:			Phone #:
Gross Income:	Check One: Hourly Daily Weekly Monthly Yearly		
	Hours Per Week:		

HOMELESS AFFIDAVIT

I, _____, hereby 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 to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor and, in accordance with statue, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that the Charity Care program is a "Payor of Last Resort" and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which CCDH's or its subsidiaries provided care.

_____ _____

PATIENT/GUARANTOR SIGNATURE **DATE**

OFFICE USE ONLY

Family Size:	Account Number(s)	Balance	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			
Recommendation:			
Prepared by:		Date:	Unit:
Approved or Denied by:		Date:	Title: