Confidential Medical and Financial Assistance Application

Facility:	Acct #:	Patient Name:	SSN:	DOB:
Patient Address:				
Patient Home Phone:		Patient Work Phone:		
Type of Service: (circle one) **ER OP IP** **Co-Pay Amount: $ ____________________**		Service Date: ______/______/______ to ______/______/______		

SECTION A: MEDICAL ASSISTANCE SCREENING – Please circle answer **"Y"** for yes to **"N"** for no.

1. Is the patient under the 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" insurance policy that the premium has lapsed? Y / N

SECTION B:

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 ❑ Annually	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	❑ Living on Saving/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 ❑ Annually	
	Hours Per Week:	

SECTION C: HOMELESS AFFIDAVIT

EW:
DOA:

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

____
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 consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Karykeion Charity Care program(s) is a "Payor of Last Resort" and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which Karykeion or its' subsidiaries provided care.

____ ________________
PATIENT/GUARANTOR SIGNATURE **DATE**

SECTION D:

FINANCIAL ASSISTANCE SCREENING

Total Number of Department Family Members in Household_ _ _ _ _

(Include patient, patient's spouse and/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 and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $______________________

Calculate Income to FPG Ratio: $ _________________________

Gross Annual Income / (divide by) FPG Based on Family Size: _ _ _ _ %

SECTION E:

OFFICE USE ONLY

Family Size:		Account Number(s)	Pt Type (Inpatient, Outpatient, ER)	Balance	W/O Amount
Gross Annual Family Income:	$			$	$
FPG based on Family Size:	$			$	$
Current Hospital Charges (w/ in 6 months):	$			$	$
Income/FPG:	%			$	$
Income X 2:	$			$	$
Total Hospital Charges:	$				
Recommendation:					

__________________ ____________________________________ ________
Prepared By Date

__________________ ____________________________________ ________
Examined By Date

____ ________ _________________
Approved or Denied by Date Title

Denial Reason: