 AHMC Healthcare Inc.	REVENUE CYCLE PROCEDURE	Revenue
	PATIENT ACCESS	Page: 11
	CHARITY CARE P	Original Date: 06/01/06
	CHARITY CARE POLICY	Revised Date: 12/15/06

Exhibit B – Confidential Financial Application

AHMC 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 to “N” for no.

- | | | | |
|---|-------|---|-------|
| 1. Is the patient under age 21 or over age 65? | Y / N | 5. Is the patient pregnant, or was the admission pregnancy related? | Y / N |
| 2. Is the patient a single parent of a child under age 21? | Y / N | 6. Will the patient potentially be disabled for 12 months? | Y / N |
| 3. Is the patient a caretaker or guardian of a child under 21? | Y / N | 7. Is the patient a Victim of Crime? | Y / N |
| 4. Is the patient a married parent of a minor child?
<i>If yes, does the patient have a 30-day incapacitation?</i> | 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/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 \$ _____ (see page 2)

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

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:	Circle One - <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		
	Hours Per Week:		
If income is \$0/unemployed, what is your means of support?	Circle One – <input type="checkbox"/> Living on Savings/Annuity <input type="checkbox"/> Live with parent/family/friends <input type="checkbox"/> Homeless <input type="checkbox"/> Shelter		

 AHMC Healthcare Inc.	REVENUE CYCLE PROCEDURE	Revenue
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SPOUSE

Responsibility Party:			
SSN:	DOB		
Home Address:		Phone #	
Work Address:		Phone #	
Gross Income:	Circle One - <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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 statute, 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 Garfield Medical Center Charity Care programs 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 Garfield Medical Center or its' subsidiaries provided care.

PATIENT/GUARANTOR SIGNATURE

DATE

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 _____

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