

Application for Charity Care/Financial Assistance Jacobson Memorial Hospital Care Center

Charity Care/Financial Assistance Policy Provided to Patient/Guarantor yes ___ no ___

PATIENT INFORMATION

Patient name _____ Birth date _____

Address _____

Home phone _____ Work phone _____

Marital status: Single ___ Divorced ___ Married ___ Legally separated ___

Social security # _____ Spouse social security # _____

Medical insurance? Yes ___ No ___

Insurance company (s) _____ Insurance claim number (s) _____

Employer _____

Employer address _____

How long employed with this employer _____ If unemployed, last date worked _____

Reason for unemployment _____

GUARANTOR/PERSON RESPONSIBLE FOR BILLS (if different from patient)

Guarantor name _____

Address _____

Relationship to patient _____

Home phone _____ Work phone _____

Marital status: Single ___ Divorced ___ Married ___ Legally separated ___

Social security number _____

Employer _____

Employer address _____

How long employed with this employer _____ If unemployed, last date worked _____

HOUSEHOLD INCOME INFORMATION

	Name	Relation	Age	Type of Income* Employer Name	Monthly Income
Patient					
Guarantor (If different from Patient)					
Spouse					
Parents (if under 18)					
Dependents					

Total monthly household income \$ _____ Total # in household _____

*Types of income: earnings, welfare, unemployment, disability, alimony, child support

PROOF OF INCOME Attach proof of all household

income for **each member** as follows:

(Check off attachments)

___ Copies of last three pay stubs for all listed (year to date) income

___ If self-employed, copy of last quarterly federal income tax filed

___ Copy of all income tax forms filed for previous year

___ Copy of all W-2s for previous year

___ Proof of child support, alimony received

___ Copy of last two welfare, unemployment, worker's comp., pension, social security or disability check stubs

___ Income from dividends

___ Other (specify) _____

HOUSEHOLD EXPENSE INFORMATION

Checking account Bank _____ Balance _____
 Savings Account(s) Bank _____ Balance _____
 Bank _____ Balance _____

ASSETS

	Describe	Estimated Value	Creditor	Balance owed	Monthly payments
House					
Other real estate					
Automobile(s)					
Other					

LIABILITIES

	Name of creditor	Creditor's address	Balance	Monthly payment
Credit cards				
Loans				
Utilities (electric, etc.)				
Internet, phone, etc.				
Insurances				
Food				
Medical expenses				
Rent				
Other				

ASSISTANCE PROGRAMS

	Applied	Received	Denied
Medicaid			
WIC			
Fuel Assistance			
Food Stamps			
Children's Health Assistance Program			
TANF (Temporary Assistance for Needy Families)			
Other _____			

INDICATE SPECIAL CIRCUMSTANCES

I understand this application applies only to bills for services provided and billed by JMHCC and per current JMHCC Charity Care/Financial Assistance policies. I authorize release of my financial records to JMHCC and authorize investigation of all matters contained in this financial disclosure.

I hereby release JMHCC and its representatives from liability for any acts of commission or omission, communication or disclosure which are made pursuant to such an investigation

Guarantor signature _____ Date _____

Spouse signature _____ Date _____

FOR JMHCC BUSINESS OFFICE USE ONLY - DO NOT FILL IN THIS SECTION

Income \$ _____ /month x12 months = \$ _____ /year

Total household members _____

Total balances \$ _____

Non-eligible balances \$ _____

Total balances \$ _____

Eligible for free or discounted services? yes _____ no _____

Income threshold and discount _____

Description of free or discounted services - current balances _____

Description of free or discounted services - future balances _____

Description of payment plan(if applicable) _____

Description of counseling – potential payment sources for future services _____

Recommendation of Finance Committee:

Date _____ Approved _____ Denied _____

Explanation _____

Notification of applicant date _____

Charity Care/Financial Assistance Worksheet and Spreadsheet completed yes _____ no _____