

## Instructions – Request for Charity Care

### Step 1: Complete the section titled, “Please List All Monthly Household Income.”

This section must list total gross household income received monthly. If your household size includes a child of legal working age who is employed, you must list their income as “Other Income.”

If you have no income and you reside with someone or you have someone helping you with your living expenses, please have that person write a brief note stating the current arrangement surrounding your residency. This note needs to be dated and reflect their signature.

### Step 2: Enclose required documentation

If you have reflected income under “Wages,” you will need to include copies of 3 months’ pay stubs from your employer. If you are married, your spouse’s income will be combined with yours and we will need copies of his/her 3 months’ pay stubs as well.

If you listed income under “Public Assistance,” please provide a copy of your Award Letter from the state.

If you listed income under “Social Security Benefit,” please provide a copy of your Social Security Administration Letter.

If you listed income under “Worker’s Comp” or “Unemployment,” please provide a copy of your Compensation or Benefit Letter.

If you listed income under “Alimony” or “Child Support,” please provide a copy of your Divorce Decree.

If you listed income under “Pensions,” “Military Retirement,” or “VA Benefits,” please provide a copy of your Benefit Letter.

If you listed income under “Other Income,” please provide records and/or proof of income and the type of income (i.e., a copy of your child’s pay stubs).

Please note that “Combined Total Monthly Income” refers to the total monthly income you, your family members and/or members in the household earn in a month *before* taxes are taken out.

If you indicated that you have a household checking or savings account, provide the most recent bank statement for each account showing balance and activity for at least 30 days.

If you indicated that you or a spouse have investment(s) (stocks, bonds, mutual funds, IRA, CD, 401K, trust funds, etc.), please provide proof of the value(s).

Motor vehicles include automobiles, motorcycles, scooters, snowmobiles, etc.

On behalf of \_\_\_\_\_

**Confidential Financial Statement – Request for Charity Care**

Date \_\_\_\_\_

Guarantor Name and Address \_\_\_\_\_

Patient Name \_\_\_\_\_ Service Date(s) \_\_\_\_\_

Account Number(s) \_\_\_\_\_ Balance Due \$ \_\_\_\_\_

**Please provide the documents listed below to verify your income and medical expenses:**

- Pay stub(s) from employer(s) for the last three (3) months
- Income tax return (recent year)
- Bank statements for the last three (3) months
- Proof of investment value(s)

Failure to return this application form and/or the requested information within 14 calendar days may result in denial of your charity application.

**Please list all monthly household income:**

Gross Wages	\$ _____
Public Assistance	\$ _____
Social Security Benefits	\$ _____
Workers Comp	\$ _____
Alimony	\$ _____
Unemployment	\$ _____
Child Support	\$ _____
Pensions	\$ _____
Military Retirement	\$ _____
VA Benefits	\$ _____
Investment Income	\$ _____
Other Income	\$ _____
<b>Combined Total Monthly Income</b>	<b>\$ _____</b>

On behalf of \_\_\_\_\_

Number of Dependents \_\_\_\_\_

Number in Household \_\_\_\_\_

**Does your household have a checking account?**

\_\_\_\_ Yes \_\_\_\_ No If yes, balance \$ \_\_\_\_\_

**Does your household have a savings account?**

\_\_\_\_ Yes \_\_\_\_ No If yes, balance \$ \_\_\_\_\_

**Do you have a life insurance policy?**

\_\_\_\_ Yes \_\_\_\_ No If yes, value \$ \_\_\_\_\_

**Does your household have any investments?**

\_\_\_\_ Yes \_\_\_\_ No If yes, value \$ \_\_\_\_\_

**Do you own any properties other than your primary residence?**

\_\_\_\_ Yes \_\_\_\_ No If yes, value \$ \_\_\_\_\_

**How many motor vehicles do you own?** \_\_\_\_\_

Value \$ \_\_\_\_\_

The above statement is being given to the hospital to determine my ability or inability to pay my debt. I understand that the information provided by me is subject to verification by the hospital. I understand that any false information provided by me will result in a denial of any hospital financial assistance. Financial assistance is available only after all other forms of reimbursement (health insurance, Medicaid, or third party insurance) have been exhausted.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_