**APPLICATION FOR CHARITY CARE COVERAGE**

**Applicant Information**

|  |  |
| --- | --- |
| **Patient Name** |  |
| **Address** |  |
| **City** |  |
| **State** |  |
| **Zip** |  |
| **County** |  |
| **Is patient married?** | **Y / N** |
| **Is there medical insurance?** | **Y / N** |
| **Number of people** **living in household?** |  |
| **Phone** |  |
| **Patient Birthdate** |  |
| **Social Security Number** |  |

**If the patient is a minor, the following questions apply to the parents or legal guardians.**

**List People Living in Your Household**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Relationship** | **Date of Birth** | **Student or Working?** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

**Employment Income (*Please include all sources of income including spouse and other income)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employer & Type of Work** | **Estimate of Hours worked and** **Rate of Pay** | **Monthly Income** | **Yearly Income** | **Source (Self, Spouse or other)** |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |

**Additional Questions**

|  |  |  |
| --- | --- | --- |
|   | **Yes**  | **No** |
| Have you applied for any other coverage, such as Medicaid, QHP with the Affordable Care Act, and / or Medicare? |   |   |
| Is the care you received at Magee General Hospital the result of an accident? |   |   |

**Other Income / Assistance**

|  |  |
| --- | --- |
| **Source** | **Amount ($)** |
| **Applicant** | **Spouse** | **Children** |
| **Social Security** |   |   |   |
| **SSI** |   |   |   |
| **VA / Pensions** |   |   |   |
| **Retirement** |   |   |   |
| **Rentals** |   |   |   |
| **Other** |   |   |   |

|  |
| --- |
| **Expense Information *(We use this information to get a more complete picture of your financial situation)*** |
| Monthly Household Expenses: |
| Rent/Mortgage $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Expenses $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insurance Premiums $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Utilities $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Debt/Expenses $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child support, loans, medications, other) |

**Additional Information**

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, season or temporary income, or personal loss.

**Declaration**

I declare that the answers I have given are true and correct to the best of my knowledge.

I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with employer, bank, credit report, etc.

I understand that if I do not qualify based on the information provided, I would be expected to pay the full amount of services rendered.

I further agree that in consideration for receiving health care services as a result of an accident or injury, I will reimburse Magee General Hospital from the proceeds of any litigation or settlement resulting from such act.

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

**Attachments**

***Please submit ALL that apply to this application:***

* Copy of a valid government issued picture ID
* Current Pay Stubs
* Previous year tax return
* Forms approving or denying unemployment compensation or workers compensation
* Written verification from public welfare agency or other governmental agency attesting to patient income status
	+ Food Stamps
	+ Housing
	+ Welfare cash benefit
* Written verification that patient is disabled
* Letter of support if you don’t have any income
	+ Relative / friend
	+ Shelter

Once form is completed and attachments are obtained, please mail all documents to:

Patient Financial Services

Magee General Hospital

300 Third Ave SE

Magee, MS 39111