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 statue: 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 statue: 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 ___

Revised October 2020