Application
Charity Care/Financial Assistance
Jacobson Memorial Hospital Care Center

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

PATIENT INFORMATION

Patient name: ____________________
Address: ____________________
____
Employer: ____________________
Employer address: ____________________
____________________ How long? ______
If unemployed, last date worked: ____________________
Reason for unemployment: ____________________
____

Birthdate: ____________________
Telephone: Home ____________________
Work ____________________
Marital status: ☐ S ☐ D ☐ M
Social security #: ____________________
Spouse social security #: ____________________
Do you have medical insurance? ☐ Yes ☐ No
Insurance Info: ____________________
____
Are you pregnant? ☐ Yes ☐ No

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

Guarantor name: ____________________
Address: ____________________
____
____
Relationship to patient: ____________________
Employer: ____________________
Employer address: ____________________
____

Telephone: Home ____________________
Work ____________________
Marital status: ☐ S ☐ D ☐ M
☐ Legally separated
Social security #: ____________________
How long? ____________________
If unemployed, last date worked ____________________

HOUSEHOLD INCOME INFORMATION

	Name	Relation	Age	Type of Income* Employer Name	Monthly Income
Patient					
Guarantor (if diff from pt.)					
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 Please 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, income from dividends received
- ☐ Copy of last two welfare, unemployment, worker's comp., pension, social security, or disability check stubs
- ☐ Income from dividends
- ☐ Other (please specify) ____________________
____
____

HOUSEHOLD EXPENSE INFORMATION

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

ASSETS	Describe	Estimate Value	Creditor	Balance Owed	Monthly Payments
House					
Other Real Estate					
Automobile					
Other					

LIABILITIES	Name of Creditor	Creditor's Address	Balance	Monthly Payment
Charge cards				
Loans				
Utilities (gas, electric)				
Cable, Telephone				
Insurances				
Food				
Medical Expenses				
Rent				
Other				
Other				
			TOTAL	

ASSISTANCE PROGRAMS	Applied	Received	Denied
Medicaid:	______	______	______
WIC:	______	______	______
Fuel Assistance:	______	______	______
Food Stamps:	______	______	______
Children's Health Insurance 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: PLEASE DO NOT FILL IN

Income: $__________/month X 12 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 to Finance Committee: Date __________
Finance Committee Action: _____ Approved _____ Denied _____ Date
Explanation:
____
____

Notification of Applicant: __________ Date

Charity Care/Financial Assistance Worksheet and Spreadsheet Completed: _____ yes _____ no

Date: April 2010