Charity Care Application

Date of Application_________________________________

Account(s) ____

Patient Name:______________________Date of Birth:_________________________

Phone Number (home)_____________________(cell)__________________________

Address____
Street **City** **Zip**
County:____

What is the reason the patient is applying for Charity?

◯ I am applying for a pre-approval of a physician ordered procedure.

- Please attach physicians order to application
- Physicians requested time frame_______________

◯ I am applying for existing bills

Please answer the following questions:

1. **Do you have children under the age of 18 living with you?**
   ◯ Yes
   ◯ No
2. **Are the children currently on Medicaid?**
   ◯ Yes
   ◯ No
3. **Have you been screened for Medicaid?**
   ◯ Yes
   ◯ No
4. **Are you currently receiving Food Stamps?**
   ◯ Yes (if yes, amount per month)____________________
   ◯ No
5. **Are the children receiving WIC?**
   ◯ Yes
   ◯ No

6. **Are you disabled?**
   ◯ Yes ◯ No
7. **What is your Marital Status?**
   ◯Single ◯Married ◯Divorced ◯Widowed
8. **Are you a US Citizen?**____
9. **How many people live in your home?**____
10. **Do you own a home?**____
    - If yes, what is the value of your home? __________________
    - Equity_____________
11. **Please list your banking account balances**:
    - Savings_________________________________
    - Checking________________________________

Patient's Information

Name	Social Security Number	Date of Birth	Current/Most Recent Employer	Employers Phone Number	Gross Monthly Income

<u>Note to Applicant</u>: You do not have to report income nor include a person in the household if that person is not legally responsible for the patient's Medical Bills. Example: If you have a brother or sister who lives with you and is not your legal guardian, that person is not responsible for paying your Medical bills and would not be included.

Members of Patient's Household

Name	Social Security Number	Date of Birth	Relationship	Current/Most Recent Employer & Phone Number	Gross Monthly Income

If income for any member is from Self-Employment, you may give information on business costs so that we can determine actual income to be counted. Please write details on a separate sheet of paper.

I acknowledge that all information provided is accurate and complete to the best of my knowledge and ability. I understand that no determination or approval will be made until incomplete or missing information is provided or actions required by me are completed. Incorrect information can result in denial of application.

I authorize Northridge Medical Center to take actions as necessary (including, but not limited to, conducting a check of my credit history) to verify the accuracy of the information provided on this application.

_____________________________________ _______________________

Applicant Signature Date

_____________________________________ ________________________

Financial Counselor Signature Date

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For Hospital Staff Use Only

Determination: Eligible for discounted services_____________%

Ineligible:__________Reason:____

Date Notified:_______________________Staff Signature:_________________________

Remarks: ____

Cost of preapproved procedure____

Medicare Allowable____