Charity Care Application

Patient information (include all family members applying for charity care)

	Name	Date of birth	Medical record number (if known)
1			
2			
3			
4			
5			

Who can we contact about this application?
Name:_____Phone Numbers: (1)_____(2)_____
Address:_____City/State:_____Zip Code:_____
Family Size:_____ (include spouse and dependent children)

Financial information
Attach a copy of your most recent 1040 Federal Income Tax form. Also attach your 2 most recent pay stubs showing year-to-date gross income. List all sources of monthly income for your household.

Monthly income

Earned Income:	$	Unemployment income:	$
Pension/retirement:	$	Social security:	$
County/government:	$	Child support:	$
Other:	$		

Medical assistance
Applied:_____ Date:_____ County:_____
Denied: ☐ Yes ☐ No
Comments: _____
_____

Assets (what you own)		Retirement Savings	
Checking accounts:	$	Pension/retirement:	$
Savings accounts:	$	IRA:	$
Health savings accounts:	$	Other retirement investments:	$
Other:	$	Certificates of deposit (CD):	$

The information above is true and correct to the best of my knowledge. If any details are false or incorrect, (Name of Organization) may stop any discounts I receive. (*All persons applying over the age of 18 must sign and date below.)*

*Signature*_____ *Date*_____

Signature _____ *Date* _____