FINANCIAL APPLICATION INSTRUCTIONS

PERSONAL INFORMATION:

- Print your full legal name.
- Write your home and work telephone number and give a daytime telephone where you can be reached most often.
- Write your current address and which country you presently live in.
- If you are completing this application for someone other than yourself, write the full legal name and social security number of the patient for whom this application is being completed.

HOUSEHOLD MEMBERS AND MONTHLY INCOME:

- Print the names of everyone in your household along with their ages, whether they have income or not.
- Include yourself, other related and unrelated people in your household. (use another piece of paper if you need more space.)
- Write the amount of income each household member received last month, before taxes or anything else is taken out, and where it came from, such as earnings, welfare, child support, social security and other income.
- If any amount last month was more or less than usual, write that person's usual monthly income.

PROOF OF INCOME, RESIDENCY, AND IDENTIFICATION:

- ALL APPLICANTS SHOULD ATTEMPT TO PROVIDE PROOF OF ANY OF THE FOLLOWING TO VERIFY INCOME:
  - IRS Form W-2
  - Wage and Earnings Statement Paycheck Remittance
  - Bank Statement/Records
  - Individual Tax Return
  - Social Security, Workers Compensation or Unemployment Compensation letter
  - Proof of eligibility for Government Program
  - Physician disability statement listing term of disability and documentation or proof of three or more months with no income for period of disability
  - Telephone verification by employer of patient's income
  - Other
  - You may also verify your income by: (a) having your employer provide written verification; (2) having your employer speak with a Hospital representative; or (3) providing a written or verbal statement to Hospital representative verifying your gross annual household income.
- If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in the INCOME VERIFICATION section of the Financial Assistance Application.

MONTHLY EXPENSES:

- Write the usual amount of household expenses.

SIGNATURE AND SOCIAL SECURITY NUMBERS:

- All applications should have the signature of an adult household member (unless medical problems or situations, i.e. isolation, I.C.U., etc. are certain.). If it is not possible or feasible to obtain a signature, please explain to hospital staff why signature is unavailable.

- The application must have the social security number of the adult who signs.

- If the adult does not have a social security number, write "NONE" to show that the adult does not have a social security number.

- Additional information may be required to determine your eligibility, depending upon the program for which you are applying.

ELIGIBILITY DETERMINATION:

- Eligibility will be determined based on 200% Poverty Income Guidelines.

- Approved applications cover charges at ContinueCare Hospital only.

APPLICATION FOR FINANCIAL ASSISTANCE

To apply for financial assistance, on the bill from ContinueCare Hospital, complete this application, sign your name, and return the application to the Financial Department within 30 days of your visit. Call the Financial Department If you need help at (972) 943 - 6430.

PERSONAL INFORMATION

Name: (Please Print)	Name and Social Security Number of Patient (if different from person completing application):
Home Phone #:	Work Phone#:
Address:	City/State/Zip Code:
What County do you live in?	Is Address Permanent or Temporary?

HOUSEHOLD MEMBERS AND MONTHLY INCOME

Name of Household members	Relationship to Household Member	Age and Date of Birth	Gross MONTHLY Income	MONTHLY Welfare/Child Support	MONTHLY Payments, Pensions, Retirement, Social Security	Any Other Monthly Income

INCOME VERIFICATION

Please provide any of the following types of documentation to verify your income.

(This information will be used solely for the purpose of assessing eligibility for medical assistance.)

IRS Form W-2, Wage and Earnings Statement Paycheck Remittance	Bank Statement/Records
Individual Tax Return	Government Program
Social Security, Work Comp or Unemployment Comp letter	Telephone verification by employer
Physician Disability Statement	Patient deceased
	Other

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

Other Resources: Please provide the total amount of other resources available to you, including such things as savings accounts, checking accounts, stocks, bonds, etc.: $ _____

MONTHLY EXPENSES

Rent/Mortgage payment		Car/Truck Payment	
Electric and/or Gas Payment		Child Care Expenses	
Telephone Cell Phone		Loans	
Cable/Satellite		Other: Water/Auto Insurance	

SIGNATURE AND SOCIAL SECURITY NUMBER:

I certify that all of the above is true and correct and that all income is reported. I understand that this information is being given for the determination of CHARITY CARE for services rendered at ContinueCare Hospital; and that hospital officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to immediate denial.

X _____ X _____

SIGNATURE OF ADULT HOUSEHOLD SOCIAL SECURITY NUMBER

DO NOT WRITE BELOW THIS LINE — FOR HOSPITAL USE ONLY

(Monthly income conversion: weekly x 4.33, Every 2 weeks x 2.15, Twice a Month x 2)
(Yearly income conversion: monthly x 12)

Total Household Size: Monthly Income: Yearly Income:		
Food Stamps: Y / N		
Eligibility Determination: Approved ☐ Denied ☐ Pending ☐		
Reason for Denial: Income too much ☐ Incomplete Information ☐ Other ☐		
Account This Application Applies To:	Patient:	
Signature of Determining Official:	Date:	
	Other:	
Reason applicant did not complete application (if applicable):		
Reason verbal attestation of income necessary (if applicable)		

FINANCIAL ASSISTANCE APPROVAL WORKSHEET

Office use only

Name: _____ Patient Account Number(s): _____

Date of Birth: _____ Social Security Number _____

Gross Annual Household Income: $ _____ Charges: $_____

Number in Household: _____ Amount Due:_____

Circle type of documentation or income verification provided:

- IRS Form W-2, Wage and Earnings Statement Paycheck Remittance
- Individual Tax Return
- Social Security, Work Comp or Unemployment Comp letter
- Government Program
- Telephone verification by employer
- Bank Statement/Records
- Physician Disability Statement
- Written Attestation (Patient signed Assistance Application verifying Total Yearly Income)
- Verbal Attestation (Patient verbally verified Total Yearly Income)
- Patient deceased
- Other

Circle appropriate answer in response to the following questions:

1. Is Total Gross Annual Income equal to or less than 200% of the Federal Poverty Guidelines?
(See Hospital Financial Assistance Eligibility Guidelines — Schedule A)

YES Approved for 100% financial assistance as Financially Indigent

NO Does not qualify for assistance as Financially Indigent. Continue to Step 2.

2. Is balance due after payment by all third party payors equal to or greater than 10% of Total Yearly Income?

YES Continue to Step 3.

NO Patient does not qualify for Financial Assistance.

3. Is Total Gross Annual Household Income equal to or less than 500% of the Federal Poverty Guidelines?
(See Hospital Financial Assistance Eligibility Discount Guidelines — Schedule B.)

YES Total Yearly Income is less than% of the Federal Poverty Guidelines. Approved for ____ % discount as Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule B

NO Continue to Step 4.

4. Is balance due after payment by all third party payors equal to or greater than 50% of Total Yearly Income?

YES Balance due is__ % of the total yearly income. Eligible for _____% discount as Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule C.

NO Patient does not qualify for Financial Assistance.

I. ($ _____) X (_____ %) = $ _____ 2. ($_____) - ($ _____) = $ _____

Balance Due % Discount Discount Amount Balance Due Discount Amt. Remaining Bal. Due

If Discount = $1 - $2,000: Approval by: _____ or above
If Discount = $2,001 - $5,000: _____ Approval by: or above
If Discount = Above $5,000: Director of Patient Financial Services

Date: _____ **Employee Signature:** _____