		Page(s):	Page 1 of 6
		Saved As:	PFS-A05
Subject:	Charity Care Policy Application	Formulated:	1/2015
Manual:	Patient Financial Services	Reviewed:	
Governing Board Approval	Date:	Revised:	

“Application for Uncompensated Care/Charity /Indigent Care”
To be completed by Financially Responsible Party. Please complete this
Application in its entirety.

Patient Information (A)

Date: ____/____/____ Name: _____

Account Number: _____ Patient Name: _____

Patient Information (B)


Patients Employer: _____

Patients Phone Number: (____) _____ Patients Date of Birth: ____/____/____

Patient s Address: _____ City/ State: _____

Patients Social Security Number: ____ - ____ - ____

Guarantor (Financially Responsible Party) (C)

		Page(s):	Page 2 of 6
		Saved As:	PFS-A05
Subject:	Charity Care Policy Application	Formulated:	1/2015
Manual:	Patient Financial Services	Reviewed:	
Governing Board Approval		Date:	
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As provided for in Federal Law, I hereby request that Garden City Hospital make a determination of my eligibility for uncompensated services. I understand that the information that I submit concerning my annual income and family size is subject to verification by the hospital. I also understand that if the information is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

Please fill out the following:

Total for last 12 months

- Wages: \$ _____
- Social Security \$ _____
- Strike Benefits \$ _____
- Alimony/Child Support \$ _____
- Military Allotment \$ _____
- Dividends/Interest \$ _____
- Pensions \$ _____
- Unemployment \$ _____
- Disability \$ _____
- IRA \$ _____
- Trust Account \$ _____
- Interest Income \$ _____
- Other \$ _____



		Page(s):	Page 3 of 6
		Saved As:	PFS-A05
Subject:	Charity Care Policy Application	Formulated:	1/2015
Manual:	Patient Financial Services	Reviewed:	
Governing Board Approval		Date:	
		Revised:	

Proof of income attached: { } W-2 Form { } Pay check stubs { } Tax Return

Expenses:

House/Rent Payment \$_____

Food:\$_____

Water:\$_____

Gas & Electricity:\$_____

Trash:\$_____

Child Support:\$_____

Auto Expenses:\$_____

Insurance:\$_____

Credit Cards:

Company:_____ Balance Owing:\$_____


Amount Available:\$_____

Company_____ Balance Owing:\$_____

Amount Available:\$_____

Company_____ Balance Owing:\$_____

Amount Available:\$_____

		Page(s):	Page 4 of 6
		Saved As:	PFS-A05
Subject:	Charity Care Policy Application	Formulated:	1/2015
Manual:	Patient Financial Services	Reviewed:	
Governing Board Approval		Date:	
		Revised:	

Medical Bills:

Hospital/Doctor Names _____

Amount:\$ _____

Number of family members in household: _____

Name: _____ Relationship _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Bank References:

Checking: Name/Branch: _____ Account # _____


Savings: Name/Branch _____ Account # _____

Assets:

Do you own your own Home? _____ Value: _____

Do you own other property? _____ Value: _____

Do you own your own automobiles? _____ Value _____

		Page(s):	Page 5 of 6
		Saved As:	PFS-A05
Subject:	Charity Care Policy Application	Formulated:	1/2015
Manual:	Patient Financial Services	Reviewed:	
Governing Board Approval	Date:	Revised:	


“I agree that my physician may be informed of the status of this application for uncompensated care.”

“I understand that I may be asked to prove my statements and that my eligibility statement will be subject to verification by contact with my employer, bank, credit verification and property searches.”

I affirm that the statements made herein are true and correct to the best of my knowledge.

Signature of applicant: _____ Date: ___/___/___

Witness: _____ Date: ___/___/___

 GARDEN CITY HOSPITAL		Page(s):	Page 6 of 6
		Saved As:	PFS-A05
Subject:	Charity Care Policy Application	Formulated:	1/2015
Manual:	Patient Financial Services	Reviewed:	
Governing Board Approval		Date:	
		Revised:	

HOMELESS AFFIDAVIT (if applicable)

I, _____, hereby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others and or General Relief benefits.

Patient/ Guarantor Signature

____/____/____

Date