Patient Account Services

Hospital Financial Assistance Application

Date ______________ Clerk ______________ Account # ______________

Last Name ______________ First ______________ Middle ______________

Social Security # ______________ Date of Birth ______________

Address ______________ City ______________ State ________ Zip ________ Phone ______________

Mailing Address if Different from Street Address ______________ How Long ________

Present Employer ______________ Employment Date ______________ Phone ______________

Employer Address ______________ City ______________ State ________ Zip ______________

Present Salary[1] ______________ Number of Dependents ________ Ages of Dependents ______________

Spouse's Name ______________ Present Salary ______________ SS# ______________

Present Employer ______________ Employment Date ______________ Phone ______________

Other Income ______________ Have you applied for State/Federal Aid? (yes) _____ (no) _____

If Yes, When and Type ______________

Monthly Expenses: Rent/Mortgage ________ Medical ________ Food/Utilities ________ Other ________

Listing of Assets[2] (use additional sheet if necessary)	*Market Value*	*Outstanding Debt/Liability*	*Net Value (Market Value less Debt)*
Banking Accounts: Name of Bank: ______________ Checking Balance: Savings or Investments Balance: Brokerage Accounts Balance:	 $ $ $	**N/A**	**N/A**
Primary dwelling (if owned or purchasing)	$	$	$
Automobiles Auto 1 Yr/Make/Model: ______________ Auto 2 Yr/Make/Model ______________	 $ $	 $ $	 $ $
Business & rental property Name of Properties: ______________ Location/Address of Properties: ______________	$	$	$
Farm land and other land holdings Location/Address of Properties: ______________	$	$	$

Covenant HEALTH

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Listing of Assets[2] *(use additional sheet if necessary)*	*Market Value*	*Outstanding Debt/Liability*	*Net Value (Market Value less Debt)*
Farm and/or business equipment (including livestock and crops) Description of asset: ____________________	$	$	$
Other Assets Description of asset: ____________________	$	$	$

Claims or potential third party claims seeking to recover payment of all or a significant portion of the hospital account.

Description of claim: ____________________

[1]The method of determining income shall include, but is not limited to adjusted gross income plus non-taxable retirement income (i.e., Socia Security), child support, unemployment compensation and "in-kind" payments (use of property rent free). The value of food stamps will be excluded from "in-kind" payment consideration.

[2]The guidelines for determining assets include, but are not limited to, primary dwelling (and attached land), automobiles, liquid assets, investments farm land, business property, rental property, farm and/or business equipment including livestock and crops. All real property will be considered at fai market value. The values of both real and personal property will be reduced by any existing liabilities incurred by the applicant in obtaining the assets (net assets) with the exception of primary dwelling. The primary dwelling net asset will be the amount of equity above $100,000. Actual or potentia third party liability to the patient, hospital or the guarantor by common law, contract, statute or otherwise shall be considered an asset and must be listed on the Hospital Financial Assistance application.

Patient/Guarantor Signature ____________________ Date ____________

Submit Verification of Income and Financial Assistance Application within 10 Business Days

[Internal Office Use]

ATTACH SUPPORTING DOCUMENTATION

Recommending for Charity Care Adjustment _____(yes) _____(no)[1] Amount: $____________

Basis of Charity Care Determination:

Income/Asset Qualification: ________ Catastrophic Qualification: ________

[1]Notification to patient and transaction posting to patient account.

[Approvals]

Hospital Collections Manager ____________________ Date:

Director Patient Accounting ____________________ Date:

Facility CFO[1] ____________________ Date:

Facility CAO[1] ____________________ Date: ____________ VP

Patient Accounting[1] ____________________ Date:

Executive Vice President/CFO[1] ____________________ Date:

[1]If Applicable

File Copy (Scanned) – Business Office Patient Folder