

**PLEASE PROVIDE COPIES OF THE FOLLOWING ITEMS FOR
THE CHARITY CARE FORM:**

**THIS INFORMATION MUST BE RETURNED WITHIN TWO WEEKS OR
APPLICATION WILL BE DENIED**

_____ Forms approving or denying assistance from the Department of Public Aid,
Unemployment or Worker Compensation.

_____ W-2 Withholding Statements and/or 1099

_____ Most recent Federal/State Income Tax Forms

_____ Unemployment check stubs/Paycheck (past 3 months) with YEAR TO DATE of gross
income or written statement of monthly and YEAR TO DATE of gross income from your
employer (past 3 months)

_____ Copy or proof of pension amount

_____ Statement of monthly benefits from Social Security.

APPLICATION FOR REDUCED FEE SERVICES

This is to advise that I have pursued all other avenues possible, including private insurance, governmental and charitable agencies providing funding and relief from financial obligations as well as public aid. Therefore, I hereby request that St. Mary's Hospital make a determination of my eligibility for hospital services on a reduced fee basis. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by St. Mary's Hospital personnel.

Name (Patient) Birthdate (Mo. Day Year) Social Security Number

Name (Guarantor/Responsible Party) Birthdate Social Security Number

Street Address (Guarantor) City State Zip

Telephone Marital Status Number of Dependents List Ages

MONTHLY INCOME

EMPLOYER:

SPOUSE'S EMPLOYER:

Name

Name

Address

Address

City

City

Date of hire

Date of hire

Hourly Rate \$

Hourly rate \$

Monthly Gross Income \$

Monthly Gross Income \$

Social Security Amount \$

Social Security Amount \$

Public Assistance Amount \$

Public Assistance Amount \$

Unemployment Comp Amt \$

Unemployment Comp Amt \$

Worker's Comp Amt \$

Worker's Comp Amt \$

Alimony Amount \$

Alimony Amount \$

Child Support Payment Amt \$

Child Support Payment Amt \$

MONTHLY INCOME (Continued)

Pension Amount.....\$ _____
Source _____
Rental Income Amount.....\$ _____
Source _____
Dividends/Interest Income.....\$ _____
Source _____
Other Income Amount.....\$ _____
Source _____
TOTAL: _____

Pension Amount.....\$ _____
Source _____
Rental Income Amount.....\$ _____
Source _____
Dividends/Interest Income.....\$ _____
Source _____
Other Income Amount.....\$ _____
Source _____
TOTAL: _____

ASSETS

Savings \$ _____
Institution _____
Checking \$ _____
Institution _____
Cash on Hand \$ _____
Stocks or Bonds _____
IRA or CD Account _____
Motor Vehicle:
Make _____ Year _____
Make _____ Year _____
Other Assets _____

Real Estate: _____
Home Address _____
Mortgage Holder _____
Value _____ Monthly Payment _____
Balance _____
Other Real Estate Address _____
Mortgage Holder _____
Value _____ Monthly Payment _____
Balance _____
If Renting:
Name of Landlord _____
Address _____
Monthly Rent \$ _____

DEBTS/EXPENSES

To Whom Owed:	Total Amount	Monthly Payment
<u>Utilities (Gas, Phone, Electric, Etc.)</u>	_____	_____
<u>Car Payments</u>	_____	_____
<u>Loans</u>	_____	_____
_____	_____	_____
_____	_____	_____
<u>Credit Unions</u>	_____	_____
<u>Medical Bills</u>	_____	_____
<u>Charge Accts: Visa/MasterCard, Etc.</u>	_____	_____
_____	_____	_____
<u>Department Stores</u>	_____	_____
<u>Other</u>	_____	_____
_____	_____	_____
_____	_____	_____

I certify that all of the information in this form is true and correct.

Signature _____

Date _____

DO NOT WRITE BELOW THIS LINE

FOR OFFICE USE ONLY:

Determination: _____ No reduction, does not meet guidelines
 _____ No reduction, false information
 _____ Reduction granted of _____ % of \$ _____

Determination made by _____

Date _____

