McLeod Health

The Choice for Medical Excellence

Application for Hospital Sponsored Charity

Patient Name: _____ Account: _____

Address: _____ Dates of Service: _____

City, State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____

Patient SSN: _____ Date of Birth: _____

PATIENT/FAMILY INCOME:

Tax Year: _____ $ _____

Last 3 months prior
to application: $_____

Number of Family Members: _____

Family: a family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as member of one family.

Income: any wages earned, AFDC, SSI, VA, Social Security, Child Support, Alimony, Disability, etc., received by any family member.

For Hospital Sponsored Charity To Be Approved, Income Information Must Be Provided.

I certify that the above information is true and accurate to the best of my/our knowledge. Further, I will make application for any assistance (Medicaid, Insurance, or any other funding) which may be available for payment of my hospital charges. I will assign or pay to McLeod Medical Center the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that McLeod Medical Center may re-evaluate my financial status and take whatever action may become appropriate for collection of unpaid balance.

Date Signed: _____ Applicant's Signature: _____

Date Received: _____ Application Amount: $ _____

Income Verified: _____ (Y / N)
Determination of Eligibility pended
for additional information:
Date: _____ Initials: _____

Amount Approved
for Charity: $ _____

Amount due from
Patient/Responsible Party $ _____

Application Approved: _____ Notification Sent: _____/_____/_____

Application Denied: _____ Reason Denied: _____

Authorized By: _____ _____

Hospital Representative Date

Seq: #2606