APPLICATION FOR UNCOMPENSATED CARE & MEDICAL INDIGENT PROGRAM

Patient's Full Name ________________ Service Requested ________________

Patient's Date of Birth ________________ Patient's SS# ________________

Guarantor's Full Name ________________ Spouse __________ Phone __________

Present Street Address ________________ City __________ State __________ Zip __________

Previous Address if above is less than two years ________________

Employer ________________ Spouse Employer ________________

Name of nearest relative not living with you ________________

Address ________________ Relationship __________ Phone __________

LIST BELOW, THE TOTAL FAMILY ANNUAL INCOME OF ALL THE MEMBERS OVER 18 YEARS OF AGE:

Wages	________	Alimony	________
Farm or Self Employ	________	Child Support	________
Public Assistance	________	Military Family Allotment	________
Social Security	________	Pensions	________
Unemployment Comp	________	Dividends, Interest, Rent	________
Workman's Comp	________	Strike Benefits	________

TOTAL INCOME ________

LIST BELOW, THE TOTAL FAMILY ASSETS: $ ________

Checking Account	________	Real Estate Owned	________
Savings Account	________	Automobile Owned	________
Certificate of	________	Stocks & Bonds	________
Deposit	________	Other: * Farm Equip/Livestock	________
Securities	________		

LIST BELOW, YOUR TOTAL OBLIGATIONS:$ ________

Rent	________	Credit Card Payment	________
House Payment	________	Finance Companies	________
Car Payment	________	Make & Model of Cars	________
Other	________	**TOTAL OBLIGATIONS**	________

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I GIVE PERMISSION TO VERIFY THE ABOVE INFORMATION.

Signature ________________ Date __________

Number of Household Members ________________ Ages of Household Members ________________

Approved ________________ Date __________ Denied ________________ Date __________

Comments: ________________

____

NEWMAN REGIONAL HEALTH
UNCOMPENSATED & MEDICAL INDIGENT HEALTH CARE
PROGRAM

STATEMENT OF PURPOSE

To provide assistance for healthcare to patients who cannot afford to pay and who are not covered by other programs including health insurance, or who are not eligible for benefits from the Jones Foundation or other charitable funds. Written notice of non-qualification may be requested. This facility does not discriminate against a patient because of race, creed, color or national origin. Patient eligibility is determined by family income and assests.

GUIDELINES - VERIFICATION OF INCOME AND ASSESTS

Patient eligibility for uncompensated health care is determined by measuring family income against the Income Poverty Guidelines established by the Community Services Administration. To verify annual income, the applicant will be required to provide the following:

1. Must be a U.S. Citizen (an exception must be approved by the CFO).
2. Current Pay Stubs
3. Copy of your most current income tax return, including all schedules.
4. Any applicable forms approving or denying unemployment compensation or Workers' Compensation.
5. Written verification of wages from employer if pay stubs are not available.
6. Written verification of public welfare agencies.

NEW INCOME GUIDELINES EFFECTIVE MARCH 1, 2009 ARE AS FOLLOWS:

Size of Family	Annual Family Income
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

* For family units with more than 8 members, add $3,740 for each additional member
* Students, regardless of their residence, who are supported by their parents or other related by birth, marriage, or adoption are considered to be residing with those who support them.
* Assets are reported as a part of the application. If there is sufficient assets to pay account, then payment will be expected.
* Applications must be completed within 90 days of service. Determination of eligibility will be made within thirty working days and the applicant will receive written notice of acceptance or denial.
* Applications may be obtained from the Credit/Collections Coordinator or the patient Accounts Supervisor in the Patient Accounts Department Monday through Friday from 8:00 a.m to 4:30 p.m.

MEDICAL INDIGENT GUIDELINES

For medical bills that are more than 50% of applicants household gross income. Applicant must provide proof of all outstanding medical expenses.