



**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	_____
<b>TOTAL INCOME</b>	_____		

**LIST BELOW, THE TOTAL FAMILY ASSETS: \$ \_\_\_\_\_**

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

**LIST BELOW, YOUR TOTAL OBLIGATIONS:\$ \_\_\_\_\_**

Rent	_____	Credit Card Payment	_____
House Payment	_____	Finance Companies	_____
Car Payment	_____	Make & Model of Cars	_____
Other	_____	<b>TOTAL OBLIGATIONS</b>	_____

**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, 2008 ARE AS FOLLOWS:

Size of Family	Annual Family Income
1	\$10,400
2	14,000
3	17,600
4	21,200
5	24,800
6	28,400
7	32,000
8	35,600

- \* For family units with more than 8 members, add \$3,600 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.