CHARITY CARE APPLICATION

Account #: ________________

Part 1: Applicant's Information Date: ______________________________

Patient Name: ______________________________ Date of Birth: ____________________

Applicant's Name (if different from the patient): ____

Phone Number: (home) ______________________ (cell) ______________________________

Address: ____

Street City Zip

....

Part 2: What is the reason the patient is applying for Charity?

1. I am applying for charity due to an inpatient stay at IMH.

☐ Yes Who referred you to IMH (doctor/other): ______________________________

Type of service: ____

Date of service: ____--or--

Doctor's requested timeframe: ____

☐ No

2. I am applying because I have existing bills that I cannot pay.

☐ Yes Please list the account number(s): ____________________________________

____

☐ Yes, but do not know account number(s)

☐ No

....

Part 3: Please answer the following questions from the patient's perspective:

1. How old are you? ____________
2. What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed
3. Are you currently employed?

☐ Yes Name and address of employer: ____________________________________

____

☐ No

Please Complete Entire Application

Patient's Name: ______________________________ **Date of Birth:** ____________________

4. If you are not currently employed, have you been employed in the last 90 day?

   ☐ Yes Name and address of employer: ______________________________________

   ____

   ☐ No

5. Do you have any insurance, including Medicare or Medicaid, that will be paying for services?

   ☐ Yes Name of Insurance: ______________________________________

   Policy Number: ______________________________________

   ☐ No

6. Is anyone else responsible for a portion of your bill (e.g., liability, auto insurance, worker's comp)?

   ☐ Yes Please list: ______________________________________

   ☐ No

7. Have you applied for Disability? ☐ Yes ☐ No

8. Have you applied for Medicaid recently?

   ☐ Yes, denied coverage

   ☐ Yes, it is still pending

   ☐ No

9. Are any of the service(s) you are applying for related to care for being a crime victim? ☐ Yes ☐ No

10. Do you have any insurance coverage?

    ☐ Yes Please list any insurance they have: ______________________________________

    ____

    ☐ No

....

Part 4: Household Information

1. Are you a US citizen? ______________________________
2. In which county do you live? __________________________
3. How many people live at your home? ____________________
4. What is your total gross monthly household income (including alimony, child support or any other income received monthly)? ______________________________
5. Do you own a home?

   ☐ Yes Value ____________________ Equity ____________________

   ☐ No

6. Please list your banking account balances: Savings ______________ Checking ______________

Patient:

Name	Date of Birth	Sex	Social Security Number	Employer	Gross Monthly Income

Members of Patient's Household:

Name	Date of Birth	Sex	Relationship to Patient	Social Security Number	Employer	Gross Monthly Income	Has Existing Bill

I hereby certify that the information I have provided is accurate and complete.

__________________________________ __________________________

Applicant's Signature Date