PATIENT I.D. LABEL

Date of Service

Patient Name________________________________

Patient Acct #______________________________

SSN & DOB:

To process this application in a timely manner <u>ALL</u> must be filled in ALL is applicable.

GUARANTOR/Parent:____ Phone No.____

SSN______________________________ ADDRESS: ____

D.O.B.________________________ ____

LIST ALL HOUSEHOLD INCOME:

<u>Employment:</u>

Patient $___________ Hourly, Weekly, Monthly,Yearly Employer:________________________________ Ph#_______
☐ Full Time ☐ Part Time Hrs_____ How Long_____

Spouse/Life partner $___________ Hourly, Weekly, Monthly,Yearly Employer:________________________________ Ph#_______
☐ Full Time ☐ Part Time Hrs_____ How Long_____

Self Employed
Proof Income Required

Company Name____________________________________ Annual Living income $______________

<u>All household</u>
Income

Household: Spouse or boy/girl-friend, or parents, or relatives if LIVING in the same house.
PROOF OF INCOME WILL BE REQUIRED ON ALL ACCOUNTS OVER $9,999.00

	Who Receives it:
Unemployment comp: $__________	_______________
Retirement $______________	_______________
Social Security $____________	_______________
Disability $______________	_______________
Workers Comp $____________	_______________
VA/Military $______________	_______________
Alimony/Welfare $___________	_______________
Child Support$_____________	_______________
Other income $_____________	_______________

If you have NO INCOME how are you living to cover necessities?

__Family/Relative paying my bill $___________

__Other ____________________ $____________

__Funds from College $________________

__Other ______________________________

Cap2Pay: ___Hospital Policy ____ Availity/Revpoint

Potential Comp. Income: Avg:$________________ as Verified by Availity/RevPoint

Number of DEPENDENTS:_________ TOTAL Number LIVING IN THE HOUSE_________________

Name of Spouse/S.O.____SSN________________DOB______________

Children: Include *Names, Relationship, Ages*____

____

____

ATTESTATION: By signing this form, I am saying that the information I am giving is true and complete to the best of my knowledge. I have been advised that if I knowingly give wrong information I am liable for prosecution under the state law 817.50 which states, (1) whoever shall willingly with intent to defraud, obtain or attempt to obtain goods, products, merchandise, or services from any hospital in this state shall be guilty of a misdemeanor of the second degree.

Signature of Responsible Party/Patient **Date**

CRS: Are you eligible for Medicaid? __________ Are you Sanctioned?______

What is your SHARE OF COST Amount $_________

YOU MAY BE MEDICAID ELIGIBLE IF YOU ANSWER YES TO ANY OF THE FOLLOWING:

1) Do you have biological children living your household: _____
2) Are you physically unable to work, whether you are employed or not?________
3) Are you pregnant at this time? _______
4) Are you 65 years of age or older? ______
5) Are you a U.S. citizen?_______
6) Are you disabled or applying for disability at this time?______

Do you have Health Insurance__________

Is there any 3rd Party liability__________

Do you receive food stamps ____ How much$_____

Have you applied for Assistance? __

What Agency ________________________

Do you have a valid Driver's License or Proof of Identity _____ if No, Please sign verifying no DL or Proof of Identity

____

Why Not?

Emergency/Message Contact: Name________________________ Contact# _____________________ Relationship____________________

Over to back to complete form

ALL HOUSEHOLD EXPENSES

Expenses Paid	Who pays (paid by whom)	Monthly ($)Payment	Asset Income
Mortgage/Rent	☐ me ☐ family ☐ friend ☐ life-partner ☐other		
Car Paymts	☐ me ☐ family ☐ friend ☐ life-partner ☐other		Checking: $
Auto Insur	☐ me ☐ family ☐ friend ☐ life-partner ☐other		Savings: $
Electric $	☐ me ☐ family ☐ friend ☐ life-partner ☐other		TSA/Bonds:$
Water/gas/sewage	☐ me ☐ family ☐ friend ☐ life-partner ☐other		Life Ins$
Phones	☐ me ☐ family ☐ friend ☐ life-partner ☐other		Other $
Child Care	☐ me ☐ family ☐ friend ☐ life-partner ☐other		AUTOMOBILE(S)
Child Support	☐ me ☐ family ☐ friend ☐ life-partner ☐other		Make-Model-Year
Cable/Internet	☐ me ☐ family ☐ friend ☐ life-partner ☐other		
Medical	☐ me ☐ family ☐ friend ☐ life-partner ☐other		
Medications	☐ me ☐ family ☐ friend ☐ life-partner ☐other		
Dental/Doctor	☐ me ☐ family ☐ friend ☐ life-partner ☐other		
Health Ins	☐ me ☐ family ☐ friend ☐ life-partner ☐other		
Life Ins$	☐ me ☐ family ☐ friend ☐ life-partner ☐other		Recreation Vehicles:
Loan- Credit Cards	☐ me ☐ family ☐ friend ☐ life-partner ☐other		Boat
Other expenses not specified	☐ me ☐ family ☐ friend ☐ life-partner ☐other		RV
	Total Expenses		ATV
	Number of Adults in the home (persons over 21 years of age)		Other
	Applicant's Contribution (Divide total expenses by Number of adults)		

What was your biggest expense last year:

BRIEFLY EXPLAIN YOUR NEED FOR ASSISTANCE:

Alternate Contact phone numbers OR best method for reaching you:

CURRENT CONTACT INFORMATION:

Street Address:____

Mailing Address: ____

Contact Number: C#________________________ **H#**_________________________

DO NOT WRITE BELOW

FINANCIAL COUNSELOR SIGNATURE **DATE**

JACKSON HOSPITAL Patient Financial Services USE ONLY:

☐ Follow up call for: ☐ Income ☐ Expenses Date___________ ☐ CRS notified possible XB eligible ☐ Minor children in HH, no XB

☐ **Charity Eligible** ☐ Discount Eligible ________% ☐ **Not Eligible** d/t ☐ CSE sanc'd ☐ XB denied ☐No Record ☐ Out of State

Requested Income Stmts:_______________________ ☐ SOC verified on DCF $___________________

 Application EXPIRES:_____________________________________