

HOSPITAL ACCOUNT # _____



Care without compromise

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR CHARITY CARE

Patient's Name _____ Social Security # _____
Address _____
Telephone No. (____) _____ Occupation _____ Employer _____
Employer Address _____ Employer Telephone # _____

INCOME - List combined income for yourself, spouse and other dependents from:

Table with 3 columns: Category, Total-last Month, Total-Last 12 Months. Rows include WAGES, SELF EMPLOYMENT EARNINGS, PUBLIC ASSISTANCE, SOCIAL SECURITY, UNEMPLOYMENT/WORKER'S COMP, STRIKE BENEFITS, ALIMONY, CHILD SUPPORT, MILITARY FAMILY ALLOTMENTS, PENSIONS, INCOME FROM DIVIDENDS, INTEREST, RENT RESOURCES, and TOTAL.

As a condition to providing Charity Care, you are required to submit proof of income / resources: 1) income tax returns including W-2s for the past year, 2) pay stubs, Social Security checks, Unemployment or Compensation papers for the past month. 3) other proof as requested. Proof means copies.

FAMILY SIZE - Family members living in your household

Table with 3 columns: NAME, AGE, RELATIONSHIP. Includes blank lines for entry.

NOTE: PLEASE ATTACH ANOTHER SHEET, IF ADDITIONAL SPACE IS NEEDED.

I HEREBY REQUEST THAT WINTHROP UNIVERSITY HOSPITAL MAKE A WRITTEN DETERMINATION OF MY ELIGIBILITY FOR CHARITY CARE. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT CONCERNING MY ANNUAL INCOME AND FAMILY SIZE IS SUBJECT TO VERIFICATION BY THE HOSPITAL. I ALSO UNDERSTAND THAT IF THE INFORMATION WHICH I SUBMIT IS DETERMINED TO BE FALSE, SUCH DETERMINATION WILL RESULT IN A DENIAL OF PROVIDING SERVICES AS CHARITY CARE, AND THAT I WILL BE LIABLE FOR CHARGES FOR SERVICES PROVIDED.

I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I HEREBY GIVE MY PERMISSION TO WINTHROP UNIVERSITY HOSPITAL TO VERIFY ANY INFORMATION CONTAINED ABOVE.

DATE: _____ SIGNATURE OF APPLICANT _____