APPLICATION FOR CHARITY CARE

Name ____

Type of Service ____

Date of Service ____

I certify that the enclosed information is true and accurate to the best of my knowledge. Furthermore, I will make an application for any assistance (Medicare, Medicaid, Insurance, etc.) which may be available for payment of my hospital charges, and I will take any action reasonable necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information may re-evaluate my financial status and take whatever action become appropriate.

Date of request: ____

Applicant's Signature Received ____

Midwest Medical Center
Charity Care Policy

Attachment 1-B

To ____

Account # ______________________________________

In order to determine your need for Charity Care, the following information is requested in addition to the Income Determination Form:

_______ 1. Name and address of your Employer along with paycheck stubs of the past three months.

_______ 2. Forms approving or denying Unemployment compensation or Workers Compensation.

_______ 3. Name and address of your Mortgage Holder.

_______ 4. Currrent and last years Income tax returns and corresponding W-2 forms.

_______ 5. Name and address of your Bank (s) along with checking and savings account record books, and bank statements.

_______ 6. Itemized annual earnings – alimony, child support, stocks, bonds, I.R.A.'s and certificates.

_______ 7. Children's birth certificates.

_______ 8. Copy of divorce decree.

_______ 9. Statements of monthly benefits from social Security.

______ 10. Others: ______________________________________

____

____

Additionally, you are required to please sign the attached "Release of Information" form.

Midwest Medical Center
Charity Care Policy

Attachment II

RELEASE OF INFORMATION FORM

To Whom It May Concern:

Please release financial information on:

Name ____

Address ____

Regarding ____

____

____

To: Business Officer Manager
Midwest Medical Center
One Medical Drive
Galena, IL 61036

I hereby authorize ______________________________ to release financial information to Midwest Medical Center.

Signed ______________________________ Date ____________

Witness ______________________________ Date ____________

Midwest Medical Center
Charity Care

Attachment IV

NOTIFICATION OF APPROVAL/DENIAL OF CHARITY CARE

To ____

Date Application Received ______________________________

Income Verified __________________ Yes _______________ No

Type of Verification ______________________________________

_____ The applicant is approved ____________________

Conditionally approved ____________________

For care at no charge ______________________

Of a reduction of __________________________ % of allowable charges per the Poverty Income Guidelines, or has qualified for reduction due to severe financial hardships as set forth in Charity Care Policy.

Amount provided ads uncompensated service is _____________________ .

Amount applicant is responsible for is ____________________________ .

_____ The applicant's request for fee for reduced charge services has been denied for the following reasons:

____

____

____

Date of Final Determination _________________________

Date Applicant Notified _____________________________

Determination by ____
(Signature)

Midwest Medical Center
Charity Care

Attachment V

PATIENT REPRESENTATIVE ____________________

Recommendations ____________________

____

____

____

____

Signature ____________________ Date __________

OFFICE MANAGER ____________________

Recommendations ____________________

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____

____

____

Signature ____________________ Date __________

ADMINISTRATION ____________________

Comments ____________________

____

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____

Approval __________ Yes __________ No Date __________

Signature ____________________

Attachment I-C

MIDWEST MEDICAL CENTER
CHARITY CARE POLICY

APPLICATION/DETERMINATION OF ELIGIBILITY

Date ____________________ Account Number ________________________________

Patient Name ____

Guarantor Name ____

Relationship to Patient ____

Address ____
(Number & Street) (City) (State) (Zip)

Telephone ___________________________ Social Security # _____________________

Birthdate ____________________________ Marital Status _______________________

Employer ____________________________ Occupation _________________________

Address ____
(Number & Street) (City) (State) (Zip)

Insurance Co. _________________________ Policy # ____________________________

Address ____
(Number & Street) (City) (State) (Zip)

Number of Persons in Household:

NAME	AGE	RELATIONSHIP

Attachment I-D

MIDWEST MEDICAL CENTER
CHARITY CARE POLICY

INCOME	EXPENSES
Gross Wages ________wk. ________mo.	Rent/Mortgage ________________
Interest ____________________	Utilities:
Social Security ____________________	Gas/Electric____________________
Pension ____________________	Telephone ____________________
VA Retirement Income ______________	Water ____________________
Rentals ____________________	Transportation ________________
Unemployment ____________________	Real Estate Taxes ______________
Child Support ____________________	Food ____________________
Stock/Bond/IRA Certificates ____________________	Insurance:
Railroad Retirement ______________	Life ____________________
Workmens Compensation ___________	Auto ____________________
Union Benefits ____________________	Home ____________________
Other ____________________	

DEDUCTIONS FROM PAY	DEBTS OWED SPECIFY TYPE & AMOUNT
Federal ____________________	______________________________
State ____________________	______________________________
Social Security ________________	______________________________
Union Dues ____________________	______________________________
Pension/Insurance ______________	______________________________