PRESENTATION MEDICAL CENTER
Charity Care/ NHSC Application

Patient Information

Name of Patient: _____
Date of Birth: _____
Social Security Number: _____

Please list the name and date of birth for other family members applying for assistance.
Name: _____ Birth Date: _____
Name: _____ Birth Date: _____
Name: _____ Birth Date: _____

Date(s) of Service (received or anticipated) From:_____ To:_____

Do any of the Applicants listed above have any type of health insurance such as Blue Cross, Medicare, Medicaid, or any other commercial insurance? Y or N

Person Responsible/Guarantor for Account:

Name: _____
Address: _____
Number & Street City State Zip Code
Phone Number (H): _____ Phone Number (W): _____
Family Size: _____ (Include all persons living at your residence)

Financial Information

Family Income (Most Recent 12 Months Before Taxes)

1. Is anyone in your household employed? Yes or No
2. List total gross income for each person living in your residence , over the age of 18.
3. Send with application a copy of your most recent tax return, along with verification of income stated below (such as copies of check stubs, etc.) with the Community Care Application.

List all household monthly income sources:

List Employers:	Income from Each Employer:
1. _____	$_____
2. _____	$_____
Social Services (Food Stamps, AFDC, etc.)	$_____
Social Security	$_____
Unemployment Compensation	$_____
Worker's Compensation	$_____
Alimony	$_____
Child Support	$_____
Military Family Allotments	$_____
Pension/Retirement	$_____
Rental Income	$_____
Other	$_____
Total Income:	**$_____**

SIGNATURE PAGE

I certify that the information provided is true and correct to the best of my knowledge and belief. I also authorize Presentation Medical Center investigate financial information provided. I also authorize the release of any information that is deemed necessary in making an eligibility determination. I understand that any false representation or misinformation can invalidate any discounts allowed by Presentation Medical Center.

_____ _____

(Name) (Date)

DO NOT COMPLETE – FACILITY PERSONNEL ONLY

This document was received on _____ by_____.

Presentation Medical Center

NHSC PROGRAM

Business Office Only

Name: _____

Accounts: _____ _____ _____ _____
Accounts: _____ _____ _____ _____
Accounts: _____ _____ _____ _____

Income: Total Income for last 12 Months: $_____

What type of verification was used to determine eligibility? _____

Application is: Approved _____ Denied _____
% Reduction in bill _____% Total $ Approved _____

Reason for Denial: Income Level to High _____
Other (explain) _____

Date of Determination of Eligibility for Community Care Application: _____
Date Applicant was Notified of Determination: _____

Reviewer: _____

Date application reviewed: _____