

**PRESENTATION MEDICAL CENTER**  
**Charity Care/ NHSC Application**

**Patient Information**

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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:

1. \_\_\_\_\_
2. \_\_\_\_\_

Income from Each Employer:

	\$ _____
	\$ _____
Social Services (Food Stamps, AFDC, etc.)	\$ _____
Social Security	\$ _____
Unemployment Compensation	\$ _____
Worker's Compensation	\$ _____
Alimony	\$ _____
Child Support	\$ _____
Military Family Allotments	\$ _____
Pension/Retirement	\$ _____
Rental Income	\$ _____
Other	\$ _____
<b>Total Income:</b>	<b>\$ _____</b>

**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 \_\_\_\_\_.

**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: \_\_\_\_\_