EVANS MEMORIAL HOSPITAL

Account #: _____ **CHARITY CARE APPLICATION**

Part 1: Applicant's Information Date: _____

Patient Name: _____ Date of Birth: _____

Applicant's Name (if different from the patient): _____

Phone Number: (home) _____ (cell) _____

Address: _____

Street City Zip

Part 2: What is the reason the patient is applying for Charity?

1. I have a scheduled service at EMH.
   - ☐ Yes — Who referred you for the service (doctor/other): _____
     Type of service: _____
     Date of scheduled service: _____ --or--
     Doctor's requested timeframe: _____
   - ☐ No
2. I have existing bills that I cannot pay.
   - ☐ Yes — Please list the account number(s): _____
     _____
   - ☐ Yes, but do not know account numbers
   - ☐ No

Part 3: Please answer the following questions from the patient's perspective:

1. How old are you? _____
2. What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed
3. Are you currently employed?
   - ☐ Yes — Name and address of employer: _____
     _____
   - ☐ No
4. If you are not currently employed, have you been employed in the last 90 days?
   - ☐ Yes — Name and address of employer: _____
     _____
   - ☐ No
5. Do you have any insurance, including Medicare or Medicaid, that will be paying for services?
   - ☐ Yes — Name of Insurance: _____
     Policy Number: _____
   - ☐ No
6. Is anyone else responsible for a portion of your bill (e.g., liability, auto insurance, worker's comp)?
   - ☐ Yes — Please list: _____
   - ☐ No

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Patient's Name: _____ Date of Birth: _____

7. Have you applied for Disability? ☐ Yes ☐ No
8. Have you applied for Medicaid recently?
   - ☐ Yes, denied coverage
   - ☐ Yes, it is still pending
   - ☐ No
9. Are you pregnant or have you given birth within the last 90 days? ☐ Yes ☐ No
10. Are the service(s) you are applying for related to cancer? ☐ Yes ☐ No
11. Are any of the service(s) you are applying for from an inpatient visit? ☐ Yes ☐ No
12. Are any of the service(s) you are applying for related to care for being a crime victim? ☐ Yes ☐ No
13. Do you have any insurance coverage?
    - ☐ Yes Please list any insurance they have: _____
      _____
    - ☐ No

Part 4: Household Information

1. Are you a US citizen? _____
2. In which county do you live? _____
3. How many people live at your home? _____
4. What is your total gross monthly household income (including alimony, child support or any other income received monthly)? _____
5. Do you own a home?
   - ☐ Yes Value _____ Equity _____
   - No
6. Please list your banking account balances: Savings _____ Checking _____

Patient:

Name	Date of Birth	Sex	Social Security Number	Employer	Gross Monthly Income

Members of Patient's Household:

Name	Date of Birth	Sex	Relationship to Patient	Social Security Number	Employer	Gross Monthly Income	Has Existing Bill

I hereby certify that the information I have provided is accurate and complete.

_____ _____

Applicant's Signature Date