

# REQUEST FOR FINANCIAL INFORMATION

**Please complete application and attach a copy of previous year Federal Tax return. Return application within 10 days to qualify for assistance.**

ACCOUNT #
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PATIENT NAME	AGE	PHONE #	MARITAL STS. S M D W	PATIENT SS #
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GUARANTOR	AGE	RELATIONSHIP TO PATIENT	SS #
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SPOUSE NAME	AGE	PHONE #	SS #
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APPLICANT'S ADDRESS – STREET	PREVIOUS EMPLOYER	LAST DATE EMPLOYED
CITY, STATE, ZIP	DO YOU RENT <input type="checkbox"/> OWN <input type="checkbox"/> LEASE TO OWN <input type="checkbox"/>	

GUARANTOR EMPLOYER NAME	PHONE #	SPOUSE EMPLOYER NAME	PHONE #
ADDRESS		ADDRESS	
POSITION/TITLE	HOW LONG EMPLOYED?	POSITION/TITLE	HOW LONG EMPLOYED?
GROSS MONTHLY INCOME \$	PAYDAY: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly	GROSS MONTH INCOME \$	PAYDAY: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly
<b>INCOME:</b>		<b>INCOME:</b>	
Wages	SSI	Wages	SSI
Pension	Rent Income	Pension	Rent Income
Alimony/Child	Other	Alimony/Child	Other

<b>MONTHLY EXPENSES:</b>			
Housing	Phone	Medication	Dr. Bills
Food	Clothing	Child Care	Utilities
Insurance	Car	Other	Other

COMBINED MONTHLY INCOME \$	TOTAL MONTHLY EXPENSES \$	Number of Dependents
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<b>ASSETS:</b>			
Checking Acct Balance:	Stocks/Bonds/Mutual Funds Value:	Real Estate #2 Value:	Automobile (Make/Model/Year):
Savings Balance:	Livestock Value:	Cash on Hand:	
Other (Money Market, CD's IRA's) Value:	Real Estate Value:	Automobile (Make/Model/Year):	

<b>LIST CREDIT REFERENCE AND MONTHLY PAYMENTS:</b>				
Creditor's Name and Address	Line of Credit	Balance	Monthly Payment	Up to Date?

The undersigned represents that all statements in this form are true and made for the purpose of obtaining credit. Verification may be obtained from any source named in this form. The Undersigned agrees to allow Capital Region Medical Center to contact any or all of the above references for credit verification. (continued)

## WHAT'S NEXT???

We will consider these factors in determining your eligibility:

- A. Available financial resources (all information from patients and family members will be treated as confidential)

Availability of funds includes but is not limited to:

- Savings
- Investments
- Credit availability
- Other family members
- Income from self-employment
- Alimony
- Public Assistance
- Social Security
- Strike Benefits
- Unemployment Compensation
- Workers Compensation
- Veteran Benefits
- Pension
- Child Support
- Other sources, such as income from dividends, interest or rental property

- B. Other assets, including the ability to borrow on insurance or property

- C. Excessive expenses (non-voluntary)

- D. Potential changes in financial capability in the near future

- E. Type of care (costs) such as voluntary surgery vs a true emergency

**Any insurance benefit must be assigned to the hospital prior to application for financial assistance.**

Once we receive your documentation, we will review your application for full or partial financial assistance. If you do not need financial assistance but still cannot pay your bill off within **six (6) months**, we will consider this application for our **extended payment program**.

If approved, your application will be valid for 6 months and we will consider additional CRMC visits under this agreement during that time. If your in a monthly payment plan, we will evaluate additional visits to ensure payments are appropriate for the agreement.

A Patient Account representative will let you know about the approval of this application in writing. All of your information is kept private under the strict protective guidelines of Capital Region Medical Center.

**Below is the chart for 200% of the Federal Poverty Guidelines used in conjunction with Assets, Income and Expenses when evaluating the Financial assistance criteria?**

### Sliding Scale for Charity Care 2009

FPL %	100%	100%	80%	60%	40%	20%	0%
FAMILY SIZE	100%	200%	250%	300%	350%	400%	400%+
1	\$10,830	\$21,660	\$27,075	\$32,490	\$37,905	\$43,320	
2	\$14,570	\$29,140	\$36,425	\$43,710	\$50,995	\$58,280	
3	\$18,310	\$36,620	\$45,775	\$54,930	\$64,085	\$73,240	
4	\$22,050	\$44,100	\$55,125	\$66,150	\$77,175	\$88,200	
5	\$25,790	\$51,580	\$64,475	\$77,370	\$90,265	\$103,160	
6	\$29,530	\$59,060	\$73,825	\$88,590	\$103,355	\$118,120	
7	\$33,270	\$66,540	\$83,175	\$99,810	\$116,445	\$133,080	
8	\$37,010	\$74,020	\$92,525	\$111,030	\$129,535	\$148,040	
For each add'l person add	\$3,740						

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

