

Application for Charity Care

I understand that this application is made so the Maria Parham Medical Center can determine my eligibility for Charity Care based on the established criteria on file at the Medical Center. If any information I have freely supplied proves to be untrue, I understand that the Medical Center may reevaluate my financial status and take whatever action it deems appropriate.

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I agree to tell the provider of services, within 10 days, if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses, or in the household or of any change of addresses.
- I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with my employer, bank, credit reporting agencies and property searches.
- I understand that the Medical Center is required by law to keep any information I provide confidential.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county or hospital from proceeds of any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by the Medical Center.
- I understand I can appeal a denial for uncompensated services with additional documentation within thirty (30) of the date of denial.

Further, I will make an application for any financial assistance (Medicaid, Crime Victims, etc) which may be available for payment of my Medical Center bill, and I will assign, or pay to the Medical Center, the amount recovered for its charges.

I hereby authorize Maria Parham Medical Center to obtain or exchange any information, regarding my financial status, which may be helpful in determining my eligibility for the Medical Center Charity Care.

Signature: _____ (seal) Date: _____

Spouse: _____ (seal) Date: _____

The following information will be needed to process application request for uncompensated care and should be provided to the Medical Center within the thirty days following discharge.

Proof of income must be attached before any consideration is made. Acceptable proof will be:

- Copies of the two (2) most recent pay check stubs,
- Copy of prior year W-2 forms,
- Letter from employer stating present salary (includes tips/bonuses),
- Prior year tax returns.

Proof of residency must be attached.

Copy of mortgage coupon or utility bill).

Completed Financial Assessment Form