ATTACHMENT #2

COMMUNITY MEMORIAL HOSPITAL
PO BOX 90, SOUTH HILL, VIRGINIA 23970
(434) 447-3151

FINANCIAL ASSISTANCE APPLICATION FORM

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Admission Date: _____ Discharge Date: _____

Address:

_____

_____

County: _____ Telephone Number: _____

Are you a U.S. Citizen? Yes _____ No _____

Third Party Information

Are you covered by Medicaid? Yes _____ No _____

If yes, Medicaid Number _____

Coverage Dates: From _____ To _____

Are you covered by Medicare? Yes _____ No _____

If yes, Medicare Number _____

Other Health Insurance? Yes _____ No _____

Company and Number _____

Is admission due to an accident? Yes _____ No _____

If yes, date of accident _____

Is Claim Pending? Yes _____ No _____

Was accident work related? Yes _____ No _____
If accident work related, name of employer and address

_____

_____

_____

Assets

$_____ Checking Acct Balance Institution Name _____
(Copy of last monthly statement showing balance)

$_____ Savings Acct Balance Institution Name _____
(Copy of last monthly statement showing balance)

$_____ Money Market Account $_____Stocks/Bonds (cash value)

$_____IRAs $_____Real Property (net owned)

$_____Primary Residence (net) $_____Other Assets (describe)

Gross Monthly Income for Patient and Legally Responsible Relatives

$_____ Wages
$_____ Social Security
$_____Unemployment
$_____ Child Support/Alimony
$_____ Interest
$_____ Military Pay
$_____ General Assistance - DSS
$_____ Pension Retirement
$_____ Workers Compensation
$_____ Annuity/Dividends
$_____ Awards/Settlements
$_____Other – please describe

_____

_____

_____

_____

_____

_____

$_____ Total Monthly Income $_____ Total Annual Income

Family Members in Household

Name Birth Date Relationship

You must return copies of the following documents with this application. Any application without signature and the necessary documentation will be denied.

DOCUMENTATION CHECK OFF LIST

_____ Proof of income: 2 most recent pay stubs or verification from employers

_____ Current W-2 form

_____ Current filed Federal Income Tax Return

_____ Social Security Award Letter for current year

_____ Unemployment Compensation Benefit Letter

_____ Last statements for checking, savings, stocks, bonds, annuity, etc.

_____ If no income, notarized letter from someone other than yourself or family member explaining how expenses are met.

Please submit the completed forms and all requested documentation to:

Community Memorial Hospital
Attn: Financial Specialist
PO Box 90
South Hill, Virginia 23970

Please contact the Financial Specialist at (434) 447-0815 if you have questions or require any assistance.

Authorization and Agreement

I understand that the information that I submit is subject to verification by Community Memorial Hospital (CMH). I certify that the above information and all documentation provided are true, correct, and complete. I understand that if I have deliberately given any

false information or withheld any information I am liable for prosecution for fraud. Also, any discount awarded will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances.

I give CMH permission to obtain a copy of my credit report to be used in determining eligibility for financial assistance.

Signature _____ Date _____

For Community Memorial Hospital Use Only

Discount Determination

Family Size _____ Poverty Level _____

Annual Income _____ % of Poverty Level _____

	Initial	Date
Date Application Received:	_____	_____
Income/Assets Verified:	_____	_____
Date Patient Notified:	_____	_____
Discount Percentage:	_____	_____
Discount Amount:	_____	_____
Application Processed By:	_____	_____

Approval Director Revenue Cycle: _____

Approval VP Finance: _____