MADISON PARISH HOSPITAL & RURAL HEALTH CLINIC
CHARITY CARE/ FINANCIAL ASSISTANCE APPLICATION

Patient Information			**Today's Date:**
First Name:	Middle:	Last:	Other Names:
Home Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Home Phone #:	Cell Phone #:		
Date of Birth:	Social Security #:	Do you have insurance: (circle one) Yes No	
Marital Status (circle one)	Single In a relationship Married Divorced Separated Widowed		

Household Size

Name (please list yourself in the household)	**Date of Birth**	**Social Security Number**

The following income information is mandatory for application to be reviewed:
All income must be verified for application to be considered

Household Income

Name	**3 Months Current Total Income**	**Prior Year Total Income**	**Employer:**
You	$	$	
Spouse	$	$	
Children	$	$	
Other	$	$	
	$	$	
Total	$	$	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support/Alimony					
Interest Income					
Other					
				TOTAL	$

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information and/or omissions may disqualify me from further consideration for charity care/financial assistance and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Madison Parish Hospital or the Rural Health Clinic if there is a significant change in my income. If approved for charity care/financial assistance under this application
I will comply with all rules and regulations of Madison Parish Hospital and Rural Health Clinic. I hereby acknowledge that I have read the foregoing disclosure and understand it.

Date: _____ Name (printed): _____ Signature: _____

DOCUMENTATION REQUIREMENTS FOR CHARITY CARE/FINANCIAL ASSISTANCE APPLICATION

You must provide proof of eligibility (income verification). If you cannot obtain these items that applicable to your income, please call and we will assist you in finding out what other documentation may be used to verify your income.

Wages (includes self-employment)	◯ Paycheck stub (most current 3 months)	◯ Dated letter from Employer
Social Security	◯ Award Letter	◯ Benefit Check
Self-Employment	◯ Income Tax Return and all Schedules	◯ Records of Earnings & Expenses
Unemployment Benefits	◯ Award Letter	◯ Benefit Check
Alimony/Child Support	◯ Letter from Court	◯ Child Support/Alimony Check Stubs
Workers Compensation	◯ Award Letter	◯ Check Stubs
Evidence of Denials	◯ Medicaid	

PRIOR YEAR'S INCOME TAX RETURN MUST BE INCLUDED WITH ALL APPLICATONS
Applications returned/submitted without documentation will be denied and returned

INCOMPLETE APPLICATIONS WILL BE AUTOMATICALLY DENIED

Family of 1	Family of 2	Family of 3	Family of 4	Family of 5	Family of 6	Family of 7	Family of 8	Each additional person	Poverty Level	Patient Payment Responsibility
$12,760	$17,240	$21,720	$26,200	$30,680	$35,160	$39,640	$44,120	$4,480	100%	Nominal Fee $20.00
$15,950	$21,550	$27,150	$32,750	$38,350	$43,950	$49,550	$55,150	$4,480	125%	20%
$19,140	$25,860	$32,580	$39,300	$46,020	$52,740	$59,460	$66,180	$4,480	150%	40%
$22,330	$30,170	$38,010	$45,850	$53,690	$61,530	$69,370	$77,210	$4,480	175%	60%
$25,520	$34,480	$43,440	$52,400	$61,360	$70,320	$79,280	$88,240	$4,480	200%	80%
$25,521	$34,481	$43,441	$52,401	$61,361	$70,321	$79,281	$88,241	$4,480	>200%	100%