BARNABAS HEALTH

Charity Care and Reduced Charge Charity Care Application

Facility Name:
Attention: Financial Counseling Department
Hospital Address:

Patient Information

Patients Name:_____ Date of Application:_____
Name of Guarantor (if different than patient):_____
Patient's Telephone Number:_____
Date of Service:_____ Requested Date of Service:_____
Address of Patient or Guarantor:
_____
SSN:_____ Family Size*:_____ U.S. Citizen**: [ ] Yes [ ] No [ ] Application Pending

Income Criteria

When determining eligibility for charity care, a spouse's income and assets must be used for an adult, and a parent's (parents') income and assets must be used for a minor child. Please note that income and assets does not include the following: money receipts, assets drawn down as withdrawals from a bank, sale of property, house, or car, tax refund, gifts, one time insurance payments, compensation from injury, non-cash income such as the bonus value of food or fuel produced and consumed on farms, and the inputed value of rent from owner occupied farm or non-farm housing.

Patient/family gross income equals the lesser of the following:
12 Months:_____ immediately prior to the date of service **OR**
3 Months x 4:_____ immediately prior to the date of service

Income Components

Wages before deductions	_____	Alimony	_____
Public assistance	_____	Child Support	_____
Unemployment and workers compensation	_____	Pension Payment	_____
Strike benefits from union funds	_____	Dividends	_____
Insurance or annuity payments	_____	Interest Income	_____
Income from estates and trusts	_____	Rental Income	_____
Veterans' benefits	_____	Royalties	_____
Training Stipends	_____	Net business income	_____
Military family allotment	_____	Other	_____

Asset Criteria

Cash	_____	Certificates of deposit	_____
Savings accounts	_____	Individual liquid	_____
Checking accounts	_____	Family liquid assets	_____
Corporate stocks and bonds	_____	Negotiable Paper	_____
Equity in real estate***	_____		
IRAs/Other retirement accounts	_____		
Treasury Bills	_____		

Signature

I understand that the information which I submit is subject to verification by the above listed healthcare facility and the federal or state governments. Willful misrepresentation of these facts will make me liable for all hospital charges.

If so requested by the healthcare facility, I will apply for governmental or private assistance for payment of the hospital bills.

I certify that the above information regarding family size, income, and assets is true and correct

Signature of Patient or Guardian:_____ **Date:**_____

Evaluator's Signature:_____ **Date:**_____

* Family size includes self, spouse, and minor children residing with you. Pregnant women are counted as two family members.
** Citizenship status does not affect an applicant's eligibility for charity care
*** Other than primary residence