APPLICATION FOR CHARITY CARE

Patient Name______________________________ Patient Social Security No.________________
Date of Service ______________________
Hospital Account Number_______________
Guarantor Name____________________________ Guarantor Social Security No.______________

Applicant Information:		Spouse Information:
______________________	Name	______________________
______________________	Social Security Number	______________________
______________________	Date of Birth	______________________
______________________	Medical Insurance Company	______________________
______________________	Medicaid Caseworker Name	______________________
______________________	Medicaid Caseworker Phone #	______________________

List all members of family who reside at your address:

ADDRESS:____
(Number & Street) (City, State, & Zip Code) (Phone Number)

(1). Name(Self):________________________ Age:_____ Relationship: Self____________
Occupation: ____________________ Length of time at present job:__________________
Employer:____________________________________ Phone #: __________________
Employer Address: ____

(2). Name (Spouse):_____________________ Age:_____ Relationship:__________________
Occupation:____________________ Length of time at present job:__________________
Employer:____________________________________ Phone #: __________________
Employer Address:____

(3). Name:_____________________________ Age:_____ Relationship:__________________
Occupation:____________________ Length of time at present job:__________________
Employer:____________________________________ Phone #:__________________
Employer Address:____
Full time student? (Circle One) Yes or No

(4). Name:_____________________________ Age:_____ Relationship:__________________
Occupation:____________________ Length of time at present job:__________________
Employer:__________________________________ Phone:____________________
Employer Address:____
Full time student? (Circle One) Yes or No

(5). Name:_____________________________ Age:_____ Relationship:__________________
Occupation:___________________ Length of time at present job:__________________
Employer:_________________________________ Phone:____________________
Employer Address:____
Full time student? (Circle One) Yes or No

(6). Name:_____________________________ Age:_____ Relationship:__________________
Occupation:____________________ Length of time at present job:__________________
Employer:____________________________________ Phone:__________________
Employer Address:____
Full time student? (Circle One) Yes or No

Circle the correct category on those with multiple listings:

Income Source	**Self** 1 wk/mo/yr	**Spouse** 2 wk/mo/yr	**Other Family Members:** 3 wk/mo/yr	4 wk/mo/yr	5 wk/mo/yr	6 wk/mo/yr	**Annual Total**
W2/Wages & Salary							
Farm/Self Employment							
Public Assistance/ Training Pay							
Social Security/Railroad Retirement							
Gambling/Lottery Winnings							
Unemployment/Worker's Compensation							
Strike Benefits							
Alimony/Child Support							
Estate/Trust Payments							
Military Allotment/Veteran's Pay							
Annuities/Pensions/ Regular Insurance Payments							
Rent Income/Royalties							
Interest/Dividends							
Food Stamps							
Other Income							
Total Income	$	$	$	$	$	$	$

I understand that the information within this application is used for the purpose of determining my ability to pay Beauregard Memorial Hospital for medical services. The Charity Care program does not provide any financial assistance for physician charges. This information is confidential and will not be released to any other sources. I attest that the information is true and accurate to the best of my knowledge. I understand that the information which I submit concerning my annual income and family size is subject to verification by the Hospital. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

Patient or Representative (and relationship) Date

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

DOCUMENTATION CHECKLIST

_____Proof of income- paycheck stubs for the last four payrolls or a letter from employer
_____Last filed Federal Income Tax Return

Please submit the completed forms and all requested documentation to:

Financial Counselor
P.O. Box 730
DeRidder, LA 70634

If you have any questions or need help in completing this application, please call Sherri Clark at (337) 462-7342.