



PO Box 720, 122 Pinnell St. Ripley WV 25271



Application for Charity Care

Name: Last First Middle SS#

Date of Birth Phone # (304)

Address: Street City/State Zip Code

Employer Employment Status How long Employed

Employer Address Emp. Phone:

ALL INFORMATION PROVIDED IS CONFIDENTIAL

Patients Gross Income

Other Family Income

Total Family Income

Family Size Ages:

Bank:

Account Type Balance

Account Type Balance

Account Type Balance

Own Home Buying Mortgage Balance

Rent Rent Amount

Other Assets Value

Value

Auto # 1: Make Year Amount Owed

Auto # 2: Make Year Amount Owed

Recreational Vehicles Owned: (boat, motorcycles, atv, campers, etc.) Make Year Amount Owed

(Please attach proof of income; tax return, payroll check stub and bank statement)

I certify that the above information is true and accurate to the best of my knowledge. I authorize Jackson General Hospital (JGH) to verify it's accuracy. I further authorize the employers/institutions to release such information to JGH. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonable necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Date of Request _____ Applicant's Signature _____

Applications will not be processed without proof of income for all household members and a Medicaid denial letter for each uninsured patient seeking Financial Assistance.

ELIGIBILITY DETERMINATION (For Office Use Only)

Date Application Received: _____

Type of Verification:

Income Verified: _____	Employer Verification
_____	Payroll Stubs
_____	Income Tax Return
_____	Bank Account(s)
_____	Social Security Benefit
_____	3 Notarized Letters

Budget Analysis:

INCOME
Gross Income:
Other Income:
TOTAL:
ASSETS
Home
Auto
Recreational
Other
TOTAL ASSETS:

The applicant's request has been:

Approved _____ Denied _____ Reason: _____

Date Applicant Notified _____ Approved By _____

Amount approved for Charity:

IP/OP/ER/MHHC

Original Patient Account (s)

Date of Service

Charity Approved Effective Dates of Service _____