MADISON HEALTHCARE SERVICES
APPLICATION FOR CHARITY CARE and FINANCIAL DISCLOSURE STATEMENT

Date Completed: _____

Name of Individual Completing Form: _____

This section to be filled out by hospital:
Patient Name: _____
Hospital/Clinic Billing #: _____
Medical Record #: _____

Filing this application does not guarantee approval. The determination for eligibility for charity care is a judgement made by the Administration or Board of Directors based on guidelines that are outlined in the Facility's Charity Care Policy.

Name: _____
Spouse: _____
Address: _____
_____
Phone: _____

Dependents (list each by name/age below)

_____ Age: _____
_____ Age: _____
_____ Age: _____
_____ Age: _____
_____ Age: _____
_____ Age: _____

Cash Assets:

Checking Account $ _____
Savings $ _____
CDs $ _____
Stocks $ _____
Bonds $ _____

Total Cash Assets $_____

Non-Cash Assets:

Market Value – Mortgage Balance = Equity

Residence _____ - _____ = _____
Other Property _____ - _____ = _____
Auto/Truck (1) _____ - _____ = _____
Auto/Truck (2) _____ - _____ = _____

Total Other Assets Equity $_____

Income:

Complete the information below based on household income (add all incomes of working members of household)

Source of Income	Monthly Amount	Annual Amount
Wages or Salary	$	$
Net Income from Self-Employment	$	$
Net Income from Farm	$	$
Social Security	$	$
Dividends-Interests-Rentals-Royalties	$	$
General Assistance	$	$
Pensions and Annuities	$	$
Unemployment Compensation	$	$
Worker's Compensation	$	$
Alimony	$	$
Child Support	$	$
Other (Please Specify)	$	$
	$	$
TOTAL INCOME	$	$

Uses of Cash:

Uses of Cash	Balance Owing	Monthly Payments
Bank Loans	$	$
Credit Cards	$	$
House Payment/Rent	$	$
Car/Truck Payment(s)	$	$
Insurance Payment(s) Car & Home	$	$
Utilities	$	$
Fuel (Car)	$	$
Medical Bill(s)	$	$
Food/Clothing Allowance	$	$
Other (Please Specify)	$	$
	$	$
TOTAL BILLS (Monthly)	$	$

I authorize Madison Healthcare Services to verify any information given on this application with my employer. I understand that if asked, I will submit a copy of my previous year's Federal Income Tax return or other documentation such as paychecks stubs, Social Security Income check stubs, unemployment verification, or personal property tax receipts.

I affirm that the information provided in this application is correct. Any misrepresentation or omissions may be grounds for denial of Charity Care discount.

_____ _____

Patient or Responsible Party Date

List of Required Documents
(check all that apply)

☐ Most Recent Federal Tax Return

☐ Paycheck Stub

☐ Social Security, SSI Check Stub

☐ Most Recent Bank Statement

☐ Unemployment Verification

☐ Other