*CLAYTON HEALTH SYSTEMS, INC*

Financial Assistance Application

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name Account No. or Social Security No.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Guarantor/Parent Name (if different from above) Social Security No.

Instructions: All questions must be answered. If a question does not pertain, write N/A on the line. Attach a photocopy of **one of the following** proofs of **income** to the completed form:

1. Letter of support from friend/family. Written Attestation signed.

2. Last year’s tax return statement

3. Social Security check or award letter

4. Last 2 paycheck stubs

5. Unemployment or Food Stamp award letter

6. Letter from employer- (to include employee name, hourly wage, number of hours worked.)

7. Physician Disability Statement

8. Bank Statement/Records

Citizenship (check one): \_\_\_\_\_US Citizen \_\_\_\_\_Non-US Citizen

Marital Status (check one): \_\_\_\_Married \_\_\_\_Single \_\_\_Divorced \_\_\_Separated \_\_\_\_Widowed

Name of Dependents **(legal deductions on your tax return)** Number in the Household\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_

Housing (check one): \_\_\_\_Own \_\_\_\_\_Rent \_\_\_\_Paid House/Rent Payment $\_\_\_\_\_\_\_\_\_/month

Utilities: Electricity $\_\_\_\_\_\_\_\_\_\_\_/month Gas $\_\_\_\_\_\_\_\_\_\_\_ /month Water $\_\_\_\_\_\_\_\_\_\_\_/month

Automobiles: Own (How many?) \_\_\_\_\_\_ Lease (How many?) \_\_\_\_\_\_ Car Payment (s): $\_\_\_\_\_\_\_\_\_\_\_/month

Bank Accounts/Other Assets: **(must answer all three questions)** Attach a photocopy of bank statement.

**PLEASE INCLUDE A COPY OF YOUR RECENT BANK STATEMENT FOR ANY BANK ACCOUNTS YOU MAY HAVE**

Checking Account? (Circle One) Yes or No $\_\_\_\_\_\_\_\_\_\_\_\_

Savings Account? (Circle One) Yes or No $\_\_\_\_\_\_\_\_\_\_\_\_

Additional Assets? (Circle One) Yes or No

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Include vehicles year/make/model)

**Employment-PATIENT/GUARANTOR Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employment-SPOUSE Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient/Guarantor Spouse

\_\_\_\_\_ Employed Full Time \_\_\_\_\_ Employed Full Time

\_\_\_\_\_ Employed Part Time \_\_\_\_\_ Employed Part Time

\_\_\_\_\_ Not Employed \_\_\_\_\_ Not Employed

**Other Support:**

Social Security $\_\_\_\_\_\_\_\_\_\_/month

Child Support $\_\_\_\_\_\_\_\_\_\_/month

Trust Fund $\_\_\_\_\_\_\_\_\_\_/month

Survivors Benefit $\_\_\_\_\_\_\_\_\_\_/month

Unemployment $\_\_\_\_\_\_\_\_\_\_/month

Workman’s Comp $\_\_\_\_\_\_\_\_\_\_/month

**Total Family Income $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per month (Award requires proof of income with application)**

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patient’s family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. I understand this determination is conditional and does not apply to third party claims such as lawsuits, settlements, hospital liens, or any other third-party payment or liability. Clayton Health Systems, Inc retains its rights to recover the full balance of my bill from any third-party resource to the fullest extent allowed by law. If my (our) case is selected for Indigent Care classification, I (we) give my (our) consent to the Clayton Health Systems, Inc to obtain information from any source to verify the statements I (we) have made.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guarantor Signature Date

**FINANCIAL ASSISTANCE APPROVAL WORKSHEET**

**Office use only**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Account Number(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Based off of Information from Application:

Circle appropriate answer in response to the following questions:

1. **Is Total Gross Annual Income equal to or less than 250% of the Federal Poverty Guidelines?**

(See Hospital Financial Assistance Eligibility Guidelines — Schedule A – Part 1 – Financially Indigent)

YES Approved for 100% financial assistance as Financially Indigent

NO Does not qualify for assistance as Financially Indigent. Continue to Step 2.

1. **Is Total Gross Annual Household Income equal to or less than 450% of the Federal Poverty Guidelines?**

YES Total Yearly Income is less than % of the Federal Poverty Guidelines. Approved for \_\_\_\_ % discount as Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule A – Part 2 and Part 3

NO Does not qualify for assistance.

I. ($ ) X ( %) = $ 2. ($ ) - ($ ) = $

*Balance Due % Discount Discount Amount Balance Due Discount Amt. Remaining Bal. Due*

Employee Signature Date

If Discount = $1 - $5,000 Approved by CFO ------------------------------------------------------------------

If Discount = Above $5,000: Approved by CEO ----------------------------------------------------------------