

Please return application to CHN Business Office by: _____



Community Health Network
COMMUNITY CARE
CATASTROPHIC FINANCIAL ASSISTANCE
Application

Name _____

Last _____

First _____

Mid. Initial _____

Date _____

Community Health Network exists to meet the healthcare needs of the people it serves regardless of their ability to pay. The Community Care Program has been created to provide substantial reductions in the health care bills of people who are eligible for the program. To qualify for Community Care, an individual must complete this application to determine verification of financial resources and to establish eligibility for participation. Health care bills may be reduced from 50-100% according to the individual's ability to pay.

Source: _____

COMMUNITY HEALTH NETWORK COMMUNITY CARE APPLICATION

Community Health Network's Community Care Program has been created to help determine an individual's eligibility for a reduction of their bill of 25%, 50% or 100%. The following steps are required in order to qualify for the program:

1. Written applications must be submitted to the CHN Business Services office for review.
2. Patient must live within the CHN service area as defined by zip code.
3. Proof of income must accompany all applications.
4. All available insurance must have been used and all other resources for payment exhausted.
5. Any balance remaining after eligibility has been determined will be considered self-pay and payment arrangements should be made. The Community Care reduction will not be given until payment arrangements have been made with CHN Business Services for any remaining balance on the bill.
6. If payment arrangements are not made or agreed payments are not received, any remaining Community Care reduction will be forfeited and appropriate collection action taken.

AUTHORIZATION AND VERIFICATION

I AUTHORIZE Community Health Network to verify any information given on this application in the determination of my eligibility.

I UNDERSTAND that WRITTEN VERIFICATION of my income must be provided before my eligibility can be determined for this application.

I SWEAR that the information given in this application is accurate to the best of my knowledge and truly represents my current financial status and that all insurance benefits have been paid to Community Health Network that are due them.

Falsification of the information of the application will result in termination of the Community Care agreement and the balance will be referred for formal collection.

Patient: _____ Date: _____

Responsible Party: _____ Date: _____

PROOF OF INCOME IS REQUIRED with all applications. Proof of income includes the following:

1. Last payroll check stub, W-2 forms from previous year, social security and/or pension check copy or bank statement showing social security and/or pension deposits, a signed statement from employer on company letterhead, unemployment checks or disability checks.
2. A copy of current Federal tax return.
3. Self employed applicants must provide all pages of their Federal tax return.
4. College students on student loans must provide documentation supporting the loan amount and verification of enrollment for current quarter.

COMMUNITY HEALTH NETWORK COMMUNITY CARE APPLICATION

Name of Patient: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Spouse's Name: _____ Patient's Birthdate: _____
 Responsible Party: _____ Address: _____
 City: _____ State: _____ Zip: _____ Phone: _____
 Responsible Party Spouse's Name: _____
 Number of Dependents in Family: _____
 List Names & Age: _____

RESPONSIBLE PARTY

YOURSELF

YOUR SPOUSE

Social Security Number: _____	_____
Employer: _____	_____
Employer's Address: _____	_____
City: _____	_____
Employer Phone: _____	_____
Your Occupation: _____	_____

MONTHLY INCOME SOURCES

Income From Wages	\$ _____	\$ _____	
Income From Social Security	\$ _____	\$ _____	
Income From Pensions	\$ _____	\$ _____	
Income From Public Assistance	\$ _____	\$ _____	
Income From Child Support	\$ _____	\$ _____	
Income From Unemployment/ Workman's Compensation	\$ _____	\$ _____	
Income From Dividends/Interest	\$ _____	\$ _____	
Income From Rental Property	\$ _____	\$ _____	
Bonuses	\$ _____	\$ _____	
All other sources (specify) _____	_____	_____	

(attach separate sheet if necessary)

STATEMENT OF ASSETS

Real Estate:

Street	City	County
Current Market Value	Mortgage Balance	2nd Mortgage Balance

Other Real Estate/Property:

Street	City	County
Current Market Value	Mortgage Balance	2nd Mortgage Balance

CASH AND DEPOSIT ACCOUNTS

<u>TYPE OF ACCOUNT</u>	<u>NAME OF INSTITUTION</u>	<u>ACCOUNT BALANCE</u>
Savings Account	_____	_____
Checking Account	_____	_____
Certificate of Deposit	_____	_____
IRA, Keogh, Stocks, Bonds	_____	_____
Other	_____	_____
Life Insurance, Name of Co.	_____	Cash Surrender Value _____

VEHICLES / PERSONAL PROPERTY

	<u>Make/Year</u>	<u>Loan Balance</u>	<u>Estimated Value</u>
autos/trucks	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
snowmobile	_____	_____	_____
boat/motor	_____	_____	_____
motorcycle	_____	_____	_____
motorhome	_____	_____	_____
other (specify)	_____	_____	_____

BUSINESS INTEREST (If self-employed)

Name of Business _____ Type of Business _____
Value of Real Estate Owned _____ Amounts of Liens _____
Balance Due on Loans _____ Inventory Less Indebtedness _____

STATEMENT OF MONTHLY EXPENSES

Rent _____ Telephone _____ Electricity _____ Water/Sewer _____
Heat _____ Child Support _____ Other (specify) _____

DEBTS AND OBLIGATIONS

<u>CREDITOR'S NAME</u>	<u>FOR</u>	<u>BALANCE</u>	<u>MONTHLY PAYMENT</u>
_____	Mortgage	_____	_____
_____	Auto	_____	_____
_____	VISA/Master	_____	_____
_____	Other Charge Cards	_____	_____
_____	Other Loans	_____	_____

(attach a separate sheet, if necessary.)

Have you transferred any property (real estate, stocks, bonds, savings, etc.) to someone else in the past six months? Yes _____ No _____

If yes, specify _____