Drew Memorial Hospital - Financial Assistance Application

(Note: This application must be filled out completely with supporting documentation attached to be considered.)

I hereby request that Drew Memorial Hospital make a determination of my eligibility for Drew Memorial Hospital's charity program.

1. PATIENT'S NAME**:** _____

2. SS#_____ DOB_____ Telephone_____
Address (Physical Location): _____
City_____ County_____ State_____ Zip_____
Current Occupation: _____ Employer:_____
Previous Employers: _____ _____

3. INCOME**:** List income from all sources in the family or household.

	Total for Last 3 Months	Total for Last 12 Months	For office use only
Wages (Including Farm or Self Empl)			
Social Security……..…..			
Unemployment Compensation……			
Workers' Compensation……..			
Alimony/Child Support……			
Pensions……			
Dividends, Interest, Rent……..			
Total Annual Income			

List Bank Checking/Savings Account..____ ____
List any Credit Cards……..____

4. FAMILY/HOUSEHOLD SIZE**:**

Name	Relationship/Age

5. DO YOU OWN YOUR HOME OR RENT? _____ LANDLORD_____
6. HAVE YOU APPLIED FOR A MEDICAID CARD OR ARKIDS? _____
7. IF SO, WHY WERE YOU DENIED? _____
8. WHAT STEPS ARE YOU TAKING IN ORDER TO IMPROVE YOUR CURRENT FINANCIAL SITUATION? _____

I affirm that the above information is true and correct to the best of my knowledge. I have not made any false statements, errors or omissions. *If any information I have given proves to be untrue, I understand that this constitutes fraud and that the Hospital will seek legal action as deemed necessary.*

Signature_____ Date_____

DMH is under no legal obligation to provide this charity care. It does so in order to help members of the community who are actively trying to help themselves.

Pre-Approval
_____Completed, dated, and signed application
_____Estimated household income

Completed Application
_____Medicaid determination letter
_____Proof of household income