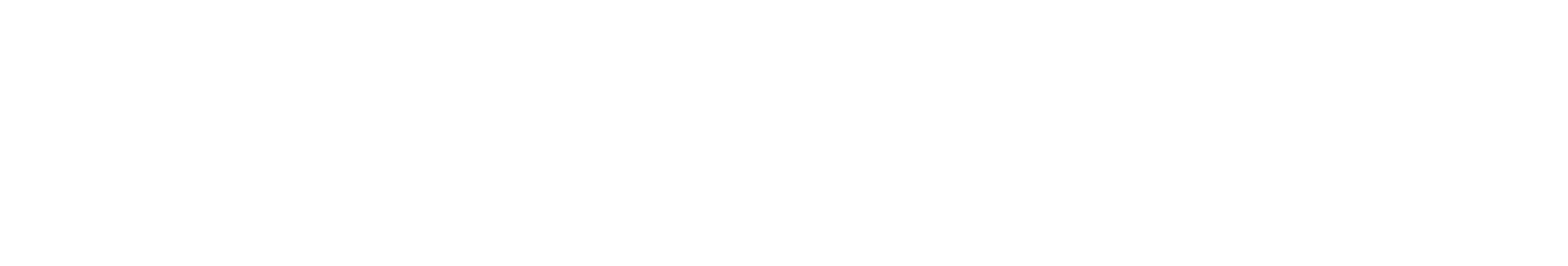
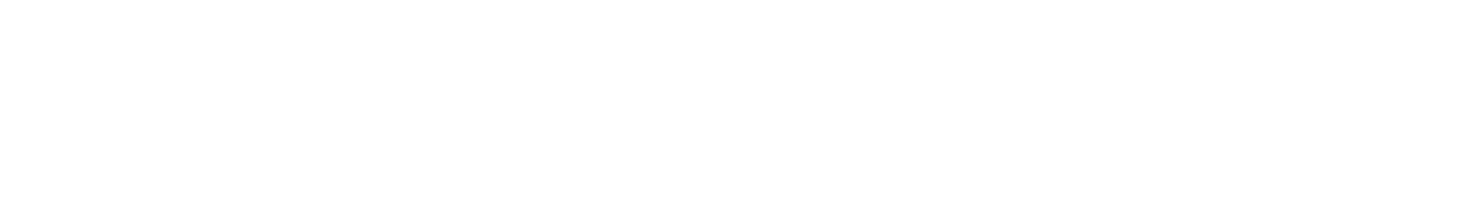
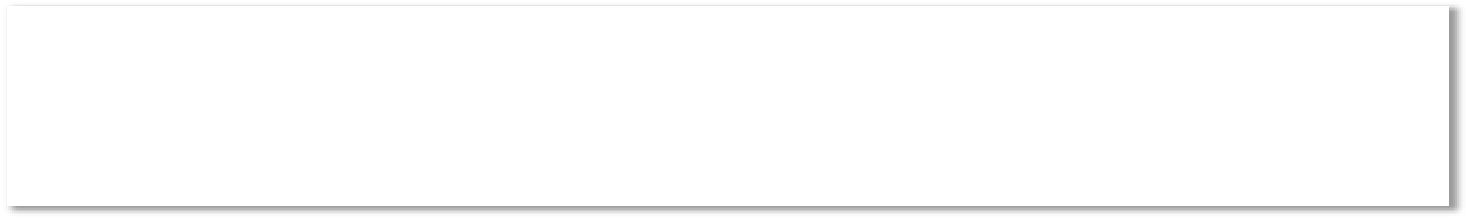
COPPER QUEEN COMMUNITY HOSPITAL

FINANCIAL ASSISTANCE PROGRAM

DATE:



**Documentation Required:**

* ✔ Verification of Identity (Driver’s license, photo ID with home address, or utility bill)
* ✔ Income (Prior year tax return, three most recent pay stubs, or other)

|  |  |  |
| --- | --- | --- |
| Patient’s Name: | | Date of Birth: |
| Primary Phone #: | Primary Language: | * Male * Female |
| **Home Address:**  *Street address 1:* | **Mailing Address:**  *Street address 1:* | **Annual Household Income:** |
| *Street address 2:* | *Street address 2:* | **Number of Household Dependents:**  (Including self) |
| *City:* | *City:* | **Email Address:** |
| *State: ZIP:* | *State: ZIP:* |

I understand that if my income is over 200% of the Federal Poverty Level, I may not qualify for this program. Therefore, I will be responsible for 20% of the full charges if am uninsured or the full patient responsibility amount if I am insured. I also verify that all the above information is true to the best for my knowledge, and I agree to immediately notify the staff at Copper Queen Community Hospital if there is any change in the information above.

I also understand this application does not cover charges billed to me from third party organizations to include but not limited to (pathology charges, radiology professional charges, etc.)

**I certify that the household size and income information shown above is correct. I understand that information verifying income and household size may be required.**

**I understand that future eligibility may be based on application for participation in current federal/state public assistance programs.**

Patient/Guardian Signature Date Staff Witness Signature Date

FOR INTERNAL USE ONLY

List all MRN’s in household:

Notes:

MM/DD/YYYY

MM/DD/YYYY

Reviewed by: Date:

Approved by: Date: Charity approval timeframe: / / through / /

* **Dis-Approved**

***To be completed by the Business Office* ☐ Approved**

Are all required documents included? ☐ Yes ☐ No Is the patient over 200% FPL? ☐ Yes ☐ No

Initial amount to be adjusted? $

Rev 11/15/2023 NO