ATTACHMENT A

KENSINGTON HOSPITAL
CHARITY CARE APPLICATION

Section One: Required Questions:

Please complete all questions in this section; Failure to complete this section could result in delays in evaluating eligibility for charity care.

Patient Information:

Patient Name: _____ Date of Birth: _____

Patient Social Security Number: _____

Street Address: _____

City/State/Zip: _____

Home Telephone: _____ Work Telephone: _____

Current Health Insurance Company Name: _____

Policy Number: _____ Group Name/Number: _____

Household Members:

Please attach additional sheets of paper if household has more than eight members.

	Name:	Relationship	Age
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Monthly Household Income:

Wages/Salaries (Before Taxes): _____ Pensions: _____

Social Security: _____ Other Disability: _____

SSI: _____ Cash Assistance: _____

Unemployment Compensation: _____ Worker's Compensation: _____

Child Support: _____ Spousal Support: _____

Veteran's Administration (VA) Benefits: _____

Annuities: _____

Other Unearned Income (Includes Trusts, Interest/Dividends, etc.): _____

_____

_____

Household Countable Resources:

Please list your available accounts and liquid assets to your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. Do not include your home, household items, vehicles, IRAs, 401(k) accounts and other non-liquid assets.

Certificates of Deposit: _____ Stocks or bonds: _____

Trust Fund: _____ Savings account: _____

Checking Account: _____ Savings Certificates: _____

U.S. Savings Bonds: _____ Christmas or Vacation Club: _____

Health Savings Account (HAS) funds: _____

Other (Please Explain): _____

_____

Section Two: Optional Questions:

If you so choose please, answer the questions below to provide a better understanding of your ability to pay for medical care. Higher-than-average or otherwise unusual expenses may result in an adjustment of income downward. Lover-than-average expenses will not result in an adjustment of income upward.

Monthly Household Expenses:

Mortgage/Rent: _____ Property Taxes: _____

Insurance: _____ Auto Loan: _____

Credit Cards (Total): _____ Water: _____

Gas: _____ Oil: _____

Electric: _____ Telephone: _____

Child Support: _____ Spousal Support: _____

Health Savings Account (HAS) Contributions: _____

Other (Please Explain): _____

_____

Monthly Medial Expenses:

Insurance Premiums: _____ Equipment: _____

Doctors' Visits: _____ Prescriptions: _____

Other: (Please Explain): _____

_____

Section Three: Verification of Income and Countable resources:

Please attach proof of income from the past 30 days and current resources to this application. Please verity all income and resources listed in Section One. If you are unable to verify some or all of your income or resources, please explain why on an attached sheet of paper. Applications will not be rejected for inability to verify income or resources, provided that reasonable explanation for the inability is given. Acceptable sources of verification include, but are not limited to:

- ☐ Pay stubs or letters from employers, listing wages before taxes.
- ☐ Award letters or bank statements showing deposits of Social Security, other disability, pension, worker's compensation or unemployment compensation payments.
- ☐ Award letters, court documents or bank statements showing deposits of child or spousal support payments.
- ☐ Documentation of other sources of income.
- ☐ If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide (e.g., grocery purchases or rent and utility payments).
- ☐ Health Savings Account (HAS) and other dedicated account statements.
- ☐ Checking and Savings account statements.
- ☐ Copy of Health Insurance card(s), if applicable.

Section Four: Certification:

Please sign and return the completed application with items listed in Section Three to <<Name of Office>>, located <<Location>>,

I certify that the information contained in this application is true and complete. I understand that willful falsification of information contained in this application will result in denial of charity care.

Signed: _____ Dated: _____