

PRESENTATION MEDICAL CENTER

Community Care Application

Patient Information

Name of Patient: _____

Please list the name and date of birth for other family members applying for assistance.

Name: _____ Birth Date: _____
 Name: _____ Birth Date: _____
 Name: _____ Birth Date: _____

Date(s) of Service (received or anticipated) From: _____ To: _____

Do any of the Applicants listed above have any type of health insurance such as Blue Cross, Medicare, Medicaid, or any other commercial insurance? Y or N

Person Responsible/Guarantor for Account:

Name: _____

Address: _____
Number & Street City State Zip Code

Phone Number (H): _____ Phone Number (W): _____

Family Size: _____ (Include all persons living at your residence)

Financial Information

Family Income (Most Recent 12 Months Before Taxes)

1. Is anyone in your household employed? Yes or No
2. List total gross income for each person living in your residence , over the age of 18.
3. Send with application a copy of your most recent tax return, along with verification of income stated below (such as copies of check stubs, etc.) with the Community Care Application.

List all household monthly income sources:

List Employers:

1. _____
2. _____

Social Services (Food Stamps, AFDC, etc.)

Social Security

Unemployment Compensation

Worker's Compensation

Alimony

Child Support

Military Family Allotments

Pension/Retirement

Rental Income

Other

SELF

Income from Each Employer:

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

Total Income:

\$ _____

Financial Information Continued

List all household monthly income sources:

List Employers:

3. _____

4. _____

Social Services (Food Stamps, AFDC, etc.)

Social Security

Unemployment Compensation

Worker's Compensation

Alimony

Child Support

Military Family Allotments

Pension/Retirement

Rental Income

Other

SPOUSE

Income from Each Employer:

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

Total Income:

\$ _____

Assets (What You Own)

Property (land, real estate, vehicle, etc.)

Property Value (excluding primary residence):

\$ _____

Cash/Bank/Investment Balances:

Checking Account(s):

\$ _____

Savings Accounts(s):

\$ _____

Investments (non-retirement):

\$ _____

Other (please detail below)

\$ _____

\$ _____

\$ _____

I certify that the information provided is true and correct to the best of my knowledge and belief. I also authorize Presentation Medical Center investigate financial information provided. I also authorize the release of any information that is deemed necessary in making an eligibility determination. I understand that any false representation or misinformation can invalidate any discounts allowed by Presentation Medical Center.

(Name)

(Date)

DO NOT COMPLETE – FACILITY PERSONNEL ONLY

This document was received on _____ by _____.