

# CCM Health CHARITY CARE APPLICATION

This information will help us assess your financial situation and determine your ability to pay for services provided by CCM Health. Please attach the following support documents as they apply to this statement. Additional information may also be requested.

- |   |   |
|---|---|
| <input type="checkbox"/> Income tax returns                           | <input type="checkbox"/> Market value statement or property tax records                                     |
| <input type="checkbox"/> W-2 forms <input type="checkbox"/> Pay Stubs | <input type="checkbox"/> Recent appraisal or <input type="checkbox"/> receipt for assets recently purchased |
| <input type="checkbox"/> Social Security or Other Benefit Statement   | <input type="checkbox"/> Bank loan application or <input type="checkbox"/> amortization schedule            |
| <input type="checkbox"/> Denial from Medical Assistance               | <input type="checkbox"/> Copy of recent bank statements - current and past three (3) months                 |
| <input type="checkbox"/>  | <input type="checkbox"/>  |

AMOUNTS OWED TO CCM Health					
MR#/Acct#	Patient Name:	Birth Date	Type of Service	Dates of Service	\$Amount
Special Circumstances:					\$ -
Have you ever received financial assistance from CCMH? Explain:					

RESPONSIBLE PARTIES (if under 18, complete for both parents)					
Name:			Name:		
Birth Date:		SSN:	Birth Date:		SSN:
Address:		Phone:	Address:		Phone #:
Are either you or your spouse a full-time student?    part-time student?    If so, name of school:					

EMPLOYER INFORMATION					
Employer			Employer		
Employer Address			Employer Address		
Phone #			Phone #		
Occupation		Yrs at Current Employer	Occupation		Yrs at Current Employer

DEPENDENTS					
Name	Age	Relationship	Name	Age	Relationship

INCOME	Source	Monthly Income	Annual Income
Income/Salary (Self/Resp Party 1)			
Income/Salary (Resp Party 2)			
Self Employment Income			
Social Security			
Pension/Disability			
Child Support/Alimony			
Unemployment Compensation			
Workers Compensation			
Public Assistance/Food Stamps			
Investment/Rental Income			
Interest/Dividends			
Other (Specify)			
<b>Total Gross Income (before taxes and non-cash expense deduction)</b>		\$	\$

Has your income changed drastically in the past 12 months? Explain

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<b>Non-Cash Expense:</b>		Annual Expense
Depreciation Expense		( \$ )
Other Non-Cash Expense		( \$ )
<b>TOTALS</b>		( \$ )

<b>ASSETS</b>	Debtor	(Monthly Payment)	- Unpaid Balance	+ Estimated Value	= Net Asset Value
Residence:	<i>First Mortgage:</i>				
Own _____ Rent _____	<i>Home Equity Loan:</i>				
Vehicles: Year/Make					
Land: # of Acres _____ Lots _____					
Business (Type):					
Rental Property					
Pleasure (Boat, Motorhome, etc.)					
Livestock (Describe):					
Other (Describe):					
<b>TOTALS</b>		\$	\$	\$	\$

<b>CASH AND INVESTMENTS</b>		Account #	Balance \$
Bank Name:	Checking Acct#:		
Bank Address:	Savings Acct#:		
Bank Name	Checking Acct#:		
Bank Address	Savings Acct#:		
Other Investments and Securities			
		<b>TOTAL CASH and INVESTMENTS</b>	\$
		<b>GRAND TOTAL NET ASSETS</b>	\$

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by CCM Health. I hereby grant permission to CCM Health and representatives to investigate the information contained herein, and to obtain a credit report.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_