

Davie County Hospital Indigent Care Application Form

Patient's Name: _____ Account # _____
 Guarantor's Name: _____
 Address: _____ Telephone: _____

Number of Family Members in the Household: Adults: _____ Children: _____ Total: _____

Patient's Employment History for the Last 12 Months:

| Place of Employment | Date | Wages per wk/mo | Total |
|---------------------|-------|-----------------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Spouse's Employment History for the Last 12 Months:

| Place of Employment | Date | Wages per wk/mo | Total |
|---------------------|-------|-----------------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

| <u>Other Income:</u> | Source | From/Until | Amount |
|-----------------------------|--------|------------|--------|
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Total Annual Income: _____

Assets/Expenses:

Cash in Bank: Checking _____ Savings _____ Bank _____

IRA, stocks or other _____

| | | |
|----------------------|-----------------------------|------------------|
| Rent/Own Home? _____ | Amount of Rent/Mortg. _____ | Est. Value _____ |
| Date Purchased _____ | Purchase Price _____ | Bal. Due _____ |

Motor Vehicles:

| | | | |
|-------------|------------|------------------|----------------|
| Model _____ | Make _____ | Est. Value _____ | Bal. Due _____ |
| Model _____ | Make _____ | Est. Value _____ | Bal. Due _____ |

Other Assets: _____

| | |
|---------------------------------|----------------|
| Loan: Bank or Finance Co. _____ | Bal. Due _____ |
| Bank or Finance Co. _____ | Bal. Due _____ |

| | |
|--------------------|----------------|
| Credit Cards _____ | Bal. Due _____ |
| _____ | _____ |

| | |
|---------------------|----------------|
| Medical Bills _____ | Bal. Due _____ |
| _____ | _____ |

Additional Information:

Do you have health insurance coverage available? Yes _____ No _____

If yes, why not available for this date of service?

Have you applied for Medicaid? Yes _____ No _____

Date applied _____

If denied, date: _____

Reason for denial: _____

Please attach a copy of the Medicaid denial letter, if denied.

Attachments:

Did you remember to include:

1. A copy of your latest Income Tax Return.
2. If you do not file an Income Tax Return, please attach a copy of your most recent payroll check stub.
3. A copy of W-2's for everyone working in your household.
4. A copy of your Social Security benefit statement.
5. A copy of the Medicaid denial letter, if denied.

I affirm that the above information is correct to the best of my knowledge.

Signature of Patient/Guarantor: _____ Date _____