CHARITY CARE APPLICATION

J. Paul Jones Hospital, 317 McWilliams Ave., Camden, AL 36726 334-682-4131
J. Paul Jones Rural Health Clinic, 319 McWilliams Ave., Camden, AL 36726 334-682-4224
J. Paul Jones Pine Hill Rural Health Clinic, 45 Industrial Drive Street, Pine Hill, AL 36726 334-963-2113

GENERAL INFORMATION AND DIRECTIONS: *THE CHARITY CARE PROGRAM PROVIDES MEDICAL CARE FOR FREE OR AT A REDUCED COST IF A PATIENT IS UNABLE TO PAY FOR MEDICALLY NECESSARY TREATMENT AND SERVICES. ELIGIBILITY FOR CHARITY CARE IS INCOME-BASED. IN ORDER TO BE CONSIDERED FOR CHARITY CARE, PLEASE SIGN AND COMPLETE THIS APPLICATION, ATTACHING ALL REQUESTED DOCUMENTATION, AND RETURN TO BUSINESS OFFICE MANAGER.*

1. **Patient Name:** ____
   First Middle Last

   SSN: __________________________ **Date of Birth:** ______________________________

   Address: ____
   Number & Street City State Zip

   Telephone: Residence ( ) ___________________ Business ( ) __________________

   Employer/Employer's Address: ____
   ____

2. **Verification of Financial Information:** The following documents will be used to verify your financial and income information:

   (a) Income/Benefits Statement from DHR Wilcox County Food Assistance Office (attached)

   (b) A copy of applicants most recent year Income Tax Return is required.

5. **Are you currently out of work?** Yes ☐ No ☐

   A. If yes, do you anticipate going back to work in the next six (6) months? Yes ☐ No ☐

   B. If yes, when? ____

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6. Expenses:

A. Living Expenses — Total/Monthly:

Mortgage/Rent $____________
Food $____________
Utilities $____________
Other (describe: _______________) $____________

B. Other Expenses (credit cards, loans, etc.). Please describe and list debt amount: ____
____
____
____

7. Public Assistance:

A. Have you applied for Medicaid or other public assistance? Yes ☐ No ☐

B. If yes, please identify/describe: ____

C. What was the approximate date of your application? ______________________________

D. What response have you received? ____

8. Other Available Health Care Coverage and Benefits:

A. Have you exhausted all other available health care coverage and benefits? Yes ☐ No ☐

B. Please describe: ____
____

I hereby request that my Charity Care Application be reviewed to determine my eligibility to receive charity care assistance to pay for some or all of my medical treatment and services. I understand that the information submitted herein is subject to verification and therefore may need to be disclosed to a third-party for such purposes. I hereby consent and give express permission for any and all verification disclosures. I also understand that if the information that I have submitted is determined to be false, it will constitute fraud. Such a determination will result in denial of my application and I will be liable for charges for any services provided.

By signing below, I hereby acknowledge that I have read this application and understand the terms and conditions contained herein.

____ ____________________
Signature of Patient or Patient's Representative Date

____
Printed Name of Patient's Representative (*if applicable*)

____
Representative's Relationship to Patient (*if applicable*)

Please Do Not Write Below This Line.

The Charity Care Application has been reviewed and is:

Approved ☐ Denied ☐

______________________________ ____________________
Signature of Reviewer Date

______________________________ ____________________
Printed Name of Reviewer Title

Comments:

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