PLEASE RETURN BY:_____

Campbell County Memorial Hospital

CAMPBELL COUNTY HEALTH

Income Guidelines for Hospital Assistance

33% ABOVE FEDERAL POVERTY GUIDELINES			34% - 50% ABOVE FEDERAL POVERTY GUIDELINES		
100% Write-Off			75% Write-Off		
Size of Household	Minimum Yearly Gross Income	Maximum Yearly Gross Income	Size of Household	Minimum Yearly Gross Income	Maximum Yearly Gross Income
1	- 0 -	16,039.80	1	16,040.80	18,090.00
2	- 0 -	21,599.20	2	21,600.20	24,360.00
3	- 0 -	27,158.60	3	27,159.60	30,630.00
4	- 0 -	32,718.00	4	32,719.00	36,900.00
5	- 0 -	38,277.40	5	38,278.40	43,170.00
6	- 0 -	43,836.80	6	43,837.80	49,440.00
7	- 0 -	49,396.20	7	49,397.20	55,710.00
8	- 0 -	54,955.60	8	54,956.60	61,980.00
9	- 0 -	60,515.00	9	60,516.00	68,250.00
10	- 0 -	66,074.40	10	66,075.40	74,520.00

51% - 85% ABOVE FEDERAL POVERTY GUIDELINES		
50% Write-Off		
Size of Household	Minimum Yearly Gross Income	Maximum Yearly Gross Income
1	18,091.00	22,311.00
2	24,361.00	30,044.00
3	30,631.00	37,777.00
4	36,901.00	45,510.00
5	43,171.00	53,243.00
6	49,441.00	60,976.00
7	55,711.00	68,709.00
8	61,981.00	76,442.00
9	68,251.00	84,175.00
10	74,521.00	91,908.00

***If income is above the required levels and your self-pay medical expenses at CCMH are equal to 40% of your yearly income, you may qualify under the catastrophic program.*

Must be a Campbell County resident for 12 months to qualify.

DIRECTION FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

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1. Complete the guarantor name, relationship to patient, guarantor's date of birth, and guarantor's social security number. If the guarantor is the same as the patient, note "Same" in this field.
2. Complete the guarantor's address, home telephone number and length of residence at this address.
3. Complete the guarantor's previous address (if current residence is less than two years), guarantor's marital status, and number of people living in household.
4. List the names and ages of dependents.
5. Complete the employer information for the guarantor or patient, depending upon who has responsibility for the balance. Please complete the same of the employer, the employer's address, the guarantor/patient's job title and length of employment. Also include the guarantor/patient's business telephone number, hourly (or salary) rate, and the monthly income (gross). If there is no employment, please note how expenses are being met.
6. Complete the previous employer information for the guarantor/patient. This includes the employer's name and address, the guarantor/patient's job title and length of employment, business telephone number, hourly rate, and monthly income (gross). If there is no prior employment, mark "N/A".
7. Complete the income information for the guarantor/patients' spouse. Include the name of the employer, the employer's address, job title/length of employment, business telephone number, hourly rate, and monthly income (gross). If the spouse is unemployed, or there is no spouse, mark "N/A".
8. Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance (and on what date). Please provide the assigned Caseworker's name and telephone number. You may attach a separate sheet if needed. Please mark N/A if this field does not apply to you.
9. Complete the questions regarding Bankruptcy and Homeowner information.
10. Please complete the banking information as requested and list the bank name. Complete the checking account number and provide the average checking account balance. Please do the same for the savings account field. If there is no savings account, please place "N/A" in the savings field.
11. Please complete the section listing other assets you may have. This includes stocks, bonds, property, boats and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark "N/A".

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

RENT/MORTGAGE: Please verify the amount you are paying in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others. Use additional paper if needed.

UTILITIES: Please list the amount paid on monthly basis for electricity, gas, water, trash and any other utilities you may pay. Please add these and place the total (for all of them) in the utilities section. If there are no monthly utilities paid, please mark "N/A" in this section and explain. Use a separate sheet of paper if needed.

CAR EXPENSES: List the Make/Model/Year of vehicle. Also include the payment amount and balance due if applicable. Please list the amount paid on monthly basis for transportation needs related to your vehicle. If there is no payment made on a monthly basis for gas, please mark the field "N/A". Please place the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide the quarterly payment by three and place the amount in this section. If you pay every six months, please divide the total amount you pay by six and place the amount in this section. If there is no monthly payment being made, please mark N/A in this section.

CREDIT CARDS: Please indicate any charge card payments you are currently making. Please indicate the monthly payment amount, to which the payment is made, the account number and the current balance due. Please indicate the credit limit for each card. Use additional paper if needed to complete this field. If you have no charge cards please note "N/A".

BANK LOANS: Please indicate any bank loans you may be paying. Indicate the monthly payment amount, to which the payment is made, the account number and the current balance due. Use additional paper if needed to completely explain this field. If you have no bank loans, please mark "N/A".

SCHOOL LOANS: Please list any educational loans you may be paying. This can include, but not limited to, college loans, private school loans (or tuition), daycare expenses or any other loans that apply to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this does not apply to you, please mark “N/A”.

FOOD: Please list the amount paid for food on a monthly basis.

MEDICATION: Please add the amount you pay on a monthly basis for medication needs. If there are several prescriptions or medications you take, please add them together and place the total amount in this section. If there are no monthly medication payments, please place “N/A” in this section.

TOTAL MONTHLY PAYMENTS: Please total all the above payments and place this amount in this section.

PLEASE READ THE FINE PRINT!!!!!!!!

DOCUMENTATION: Please notice that your signature indicates you have agreed to attach all income verification. If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

WHAT ARE YOU AGREEING TO:

1. Stating that the guarantor/patient has completed this form accurately.
2. Stating that the guarantor/patient will apply for any assistance to pay this bill. This may include acquiring a bank loan or putting the balance on your credit card.
3. Authorizing Campbell County Memorial Hospital to obtain credit information and perform a credit check.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT SHAWN AT (307) 688-1404

Campbell County Memorial Hospital
CAMPBELL COUNTY HEALTH

Standardized Financial Assistance Application

Guarantor Name:	Social Security #:	Date of Birth:	Guarantor Account #:
Spouse Name:	Social Security #:	Date of Birth:	Guarantor Account #
Guarantor Address:	City, State, Zip:	Home Phone #:	Length of Residence:
Previous Address: (less than 2 yrs)	City, State, Zip:	Marital Status:	# in Household:
Name/Relationship	Date of Birth	SS#	Employer
Guarantor Employer	Length of Employment	Address	Previous Employer
Spouse Employer	Length of Employment	Address	Previous Employer
Job Title/Length of Employment			
Business Phone #			
Hourly Rate			
Monthly Gross Income			

Office Use Only	Yearly Income	Office Use Only
	Gross Family Income:	Gross Family Income:
Guarantor Income:		
Spouse Income:		
Other Income(includes child support)		
Total		

PLEASE LEAVE YEARLY INCOME INFORMATION BLANK		
Have You Applied for Medicaid or Any State/County Assistance? (check one)		Yes_____ No_____
Application Date:	Caseworker Name/Telephone Number:	

Have You Filed Bankruptcy? (check one)		Yes_____ No_____
Chapter 7		Chapter 13
Date Filed/Discharge:		Date Filed/Discharge:
Are You a Homeowner? (check one)		Yes_____ No_____
Approximate $ Value	Balance on Loan	Years Left on Loan

Bank Information

Bank Name	Checking Account #	Avg. Checking Balance
	Savings Account #	Avg. Savings Balance
Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)		

Monthly Financial Obligations

Description	Account #	Monthly Payment	Balance
Housing: Rent--Bank Payments			
Utilities: Electricity			
Heat			
Water			
Garbage			
Phone			
Cable or Internet			
Car Expenses	Make/Model/Year	Payment Amount	Balance Due
Car Maintenance			
Car Insurance			
Total Car expense			
Credit Cards:			
Bank Loans:			
Food:			
Medical Insurance:			
Prescriptions:			
Total Expenses:			

APPLICATION WILL NOT BE REVIEWED WITHOUT THE FOLLOWING SUPPORTING DOCUMENTS:

Income Documentation Requirements if applicable:

_____ Year to Date Paystubs: To include ALL Household Income

_____ Current Year Tax Return

_____ Social Security Benefits: Social Security Income Annual Benefit Letter

_____ Child Support: Child Support Documentation or Letter Denying Receipt of Child Support from Child Support Authority

_____ All other sources of income including but not limited to Self-Employment, Unemployment, Worker's Comp, Royalties, etc.

_____ If there is no income to report, please provide a letter explaining how you are paying expenses.

Other Supporting Documentation Requirements:

_____ Copies of Most Recent Bank Statements to include checking and savings accounts

_____ Lease/Rental Agreement (if renting)

_____ Copy of Medicaid Denial Letter (if applicable)

_____ Divorce Decree (if applicable)

CERTIFICATION

1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill
3. I understand the information submitted is subject to verification: therefore, I grant permission and authorize any bank, insurance company, real estate company, financial institution and credit grantor of any kind to disclose to any authorized agent of Campbell County Memorial Hospital information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize Campbell County Memorial Hospital to perform a credit check for both guarantor/patient and spouse.

Signature(Guarantor)_____ Date_____

Signature(Spouse)_____Date_____

(For Office Use ONLY)

Comments:

Catastrophic _____

100% _____ 75% _____ 50% _____

Balance Information		Write off amount	Transaction code
A/R Balance:	_____	_____	_____
B/D Balance:	_____	_____	_____
Total	_____	_____	
A/R Balance due from patient	_____		
B/D Balance due from patient	_____		
Total due from patient	_____		

Approved By:_____ Date:_____

Denied ___Income Above Guidelines ___Medical Not 40% of Income ___Info Not Returned

Denied By:_____ Date:_____