COPPER QUEEN COMMUNITY HOSPITAL

FINANCIAL ASSISTANCE PROGRAM

 DATE:

|  |  |  |
| --- | --- | --- |
| Patient’s Name: | DOB: | SSN: |
| Primary Phone #: | Race: | Primary Language:  | * Male
* Female
 | Status: ☐ Single ☐ Married* Divorced ☐ Widowed
 |
|  |  |
| Home Address:*Street address 1* |  | Mailing Address:*Street address 1* | Employer: | Work Phone #: |
| Annual Household Income: |
| *Street address 2* | *Street address 2* |
| Number of HouseholdDependents: (including self)  |
| *City:* | *City:* |
|  |
| *State: ZIP:*  | *State: ZIP:*  |
| Email address: |

I understand that if my income is over 200% of the Federal Poverty Level, I may not qualify for this program. Therefore, I will be responsible for 50% of the full charges if am uninsured or the full patient responsibility amount if I am insured. I also verify that all of the above information is true to the best for my knowledge and I agree to immediately notify the staff at Copper Queen Community Hospital if there is any change in the information above.

Documentation Required for Determination:

* ✔ Proof of Residency (Driver’s license, photo ID with home address, or utility bill)
* ✔ Proof of Income (Paycheck stub, signed and stated statement from patient, or guardian stating income)
* A **Denial** letter from the State AHCCCS Program (optional)

I also understand this application does not cover charges billed to me from third party organizations to include but not limited to (pathology charges, radiology professional charges, etc.)

Patient/Guardian Signature Date Staff Witness Signature Date

FOR INTERNAL USE ONLY

List all MRN’s in household:

Notes:

MM/DD/YYYY

MM/DD/YYYY

Reviewed by: Date:

Approved by: Date: Charity approval timeframe: / / through / /

* **Dis-Approved**

***To be completed by the Business Office* ☐ Approved**

Are all required documents included? ☐ Yes ☐ No Is the patient over 200% FPL? ☐ Yes ☐ No

Initial amount to be adjusted? $

Rev 6/7/2018 VM