Boulder City Hospital
Quality care close to home

FINANCIAL AID/CHARITY CARE APPLICATION

Statement of Financial Condition

PATIENT: APPLICATION DATE:

ACCOUNT # (s): TOTAL ACCOUNT BALANCES:

SSN: HM PHONE: CELL PHONE:

GUARANTOR NAME: SPOUSE NAME:

HOME ADDRESS:

EMPLOYMENT/OCCUPATION

Guarantor Employer or Business Name: Position:

Employer Contact Person: Business Telephone:

Spouse Employer or Business Name: Position:

Employer Contact Person: Business Telephone:

PEOPLE IN HOUSEHOLD

Name	Relationship	DOB	Employer	Employer Telephone
1)	Patient		See above	See above
2)	Guarantor		See above	See above
3)	Spouse		See above	See above
4)				
5)				
6)				
7)				
8)				

***Total Number in Household from above:

MONTHLY INCOME

In order to determine your eligibility for charity care, please provide us with information about your gross household income. Supporting documentation should represent the last three months.

	Patient/Guarantor	Spouse/Other
(a) Monthly Salary (before taxes)	$	$
(a) Business income (after expenses)	$	$
(a) Rental Income	$	$
(a) Social Security Income	$	$
(a) Public/State Assistance	$	$
(a) Unemployment Benefits	$	$
(a) Workers Compensation Benefits	$	$
(a) Alimony or Child Support Payments ***(Received)***		
Other Income such as Scholarships, grants, etc *(please specify)*		
(a)	$	$
(a)	$	$
(s) Alimony or Child Support Payments ***(Paid)***	$	$

***Total Monthly Income x 12: *(patient/guarantor + spouse/other) (e)*

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MONETARY INCOME

Please DO NOT include any funds held in tax exempt/deferred accounts such as 401K savings accounts, 403B savings accounts, and IRA savings accounts.

	Patient/Guarantor	Spouse/Other
Checking Account Balances	$	$
Saving Account Balances	$	$
Stocks, Bonds & CDs	$	$
Other:	$	$
Other:	$	$

***Total Monetary Income: *(patient/guarantor + spouse/other)*

Please return your application with the following items. If you are unable to supply one of the documents or there are additional factors that may influence this evaluation, please submit a written statement explaining your situation.

1) **Proof of Identity** - One of the following:
   - Copy of Social Security Card
   - Copy of state issued driver's license
   - Copy of other photo ID

2) **Proof of Monetary Assets** - All of the following (if applicable):
   - Last two months checking *and* savings account statements
   - Documentation about stocks, bonds, and/or CDs

3) **Verification of Current Address** - One of the following:
   - Rent receipt or Utility Bill

4) **A copy of a state Medicaid decision/denial notice (if applicable)**

5) **Proof of Income:**
   - **Employed,** include a copy of prior year tax return and W-2 (earnings statement provided by your employer) and check stubs from previous two months.
   - **Receiving public assistance**, include copies of public assistance checks for the prior two months (I.E.: disability, unemployment pay stubs, or social security benefits.)
   - **Employment income is received in cash**, include a written statement from your employer stating your monthly income for the last two months.
   - **Self-employed**, include Schedule C of prior year tax return *and* a quarterly accountant report with a written statement declaring gross income received during the last two months.
   - **Not receiving a consistent income**, write a brief paragraph on a separate paper stating your financial situation over the last three months. Explain how or from what source you are receiving monies to pay for your basic living expenses such as food and housing.

- By signing this form you agree to be considered for charity care assistance
- You certify that all the statements made on this application are true and complete to the best of your knowledge
- If it is found that any information you provided is false, any discount on your account may be reversed and payment in full may be expected from you.

By signing below you authorize Boulder City Hospital and its representatives to check employment and credit history for the purpose of determining your eligibility for a financial discount. I understand that I will be required to provide proof of the information that I am providing.

If you are filing a third party claim or workers compensation, you agree to inform Boulder City Hospital of any payments received. The hospital retains its right to collect the original, full billed charges should you be awarded compensation for your hospital charges.

Signature Person Responsible for Bill (Guarantor): Date: