THE QUEEN'S HEALTH SYSTEMS

ATTACHMENT A

QHS Financial Assistance Application

TODAY'S DATE	TODAY'S TIME	CURRENT PATIENT?	REFERRED BY:
___/___/___	:	☐ YES ☐ NO	

INFORMATION ABOUT YOU

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH
			___/___/___

HOME ADDRESS	CITY	STATE	ZIP CODE

SEX	MARITAL STATUS	HOME PHONE	SOCIAL SECURITY NO.
☐ MALE ☐ FEMALE	☐ M ☐ S ☐ D ☐ W ☐ UNK	( ) -	

US CITIZEN	PERMANENT RESIDENT	COMMENT
☐ YES ☐ NO	☐ YES ☐ NO	

EMPLOYMENT INFORMATION

EMPLOYER NAME	WORK PHONE	OCCUPATION
	( ) -	

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

HOUSEHOLD MEMBERS

NAME	AGE	RELATIONSHIP

OTHER ASSISTANCE INFORMATION

HAVE YOU APPLIED FOR MEDICAL ASSISTANCE?	IF YES, WHAT WAS THE DATE YOU APPLIED?	IF YES, WHAT WAS THE DETERMINATION?	COMMENT
☐ YES ☐ NO	___/___/___	☐ APPROVED ☐ DENIED	

DO YOU RECEIVE ANY TYPE OF STATE OR COUNT ASSISTANCE?	IF YES, WHAT TYPE?
☐ YES ☐ NO	

UNDERINSURED INFORMATION

ARE YOU REQUESTING ASSISTANCE DUE TO INSUFFICIENT INSURANCE COVERAGE? ☐ YES ☐ NO

INSURANCE INFORMATION

INSURANCE CARRIER 1		INSURANCE CARRIER 2	
INSURANCE NAME		**INSURANCE NAME**	
ID #	**GROUP#**	**ID #**	**GROUP#**
SUBSCRIBER NAME		**SUBSCRIBER NAME**	
INSURANCE PHONE # ( ) -	EXTENSION	INSURANCE PHONE # ( ) -	EXTENSION

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List the amount of your monthly income and assets from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support for the person providing your housing and meals.

I. FAMILY INCOME	Monthly Amount	II. LIQUID ASSESTS	Current Balance
☐ Employment	$	☐ Checking account	$
☐ Retirement/pension benefits	$	☐ Savings account	$
☐ Social security benefits	$	☐ Stocks	$
☐ Public assistance benefits	$	☐ Bonds	$
☐ Unemployment benefits	$	☐ Certificates of Deposit (CD)	$
☐ Veterans benefits	$	☐ Money Market Funds	$
☐ Alimony	$	☐ Other accounts	$
☐ Rental property income	$	☐ Other accounts	$
☐ Strike benefits	$	☐ Other accounts	$
☐ Military allotment	$	☐ Other accounts	$
☐ Farm or self employment	$	☐ Other accounts	$
☐ Other income source	$	☐ Other accounts	$
Total	$	Total	$

III. OTHER ASSETS

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets and expenses. If you have no income, provide a letter of support from the person providing your housing and meals.

☐ Home	Loan Balance $		Approximate Value $
☐ Automobile	Vehicle Make	Year	Approximate Value $
☐ Additional vehicle	Vehicle Make	Year	Approximate Value $
☐ Additional vehicle	Vehicle Make	Year	Approximate Value $
☐ Other property	Type of Property		Approximate Value $
		Total	$

IV. MONTHLY EXPENSES	Amount		Amount
☐ Rent	$	☐ Health insurance	$
☐ Mortgage	$	☐ Health insurance (other)	$
☐ Car payment	$	☐ Other medical expenses	$
☐ Car payment (other vehicle)	$	☐ Medical expenses	$
☐ Car payment (other vehicle)	$	☐ Other medical expenses	$
☐ Car insurance	$	☐ Other medical expenses	$
☐ Credit card (other)	$	☐ Other medical expenses	$
☐ Credit card (other)	$	☐ Other expenses	$
☐ Credit card (other)	$	☐ Other expenses	$
☐ Credit card (other)	$	☐ Other expenses	$
Total	$	Total	$

REGISTRAR COMMENT

Do you have any other unpaid medical bills? ☐ YES ☐ NO	If yes, for what service?	Service
Have you arranged for a monthly payment plan? ☐ YES ☐ NO	If yes, what is the monthly payment?	Monthly Payment $

If you request that the hospital or its affiliates extend additional financial assistance, the hospital or affiliate may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital or affiliate of any changes to the information within ten days of the change.

Applicant Signature _____ Date _____

Relationship to Patient _____