HOOD MEMORIAL HOSPITAL

Application for Charity Care

<table>
<tr><td colspan="6">Patient Name:
Last: First: Middle:</td></tr>
<tr><td colspan="6">Guarantor:
Last: First: Middle:</td></tr>
<tr><td colspan="6">Address:</td></tr>
<tr><td colspan="2">City:</td><td colspan="2">State:</td><td colspan="2">Zip:</td></tr>
<tr><td colspan="4">Home Phone:</td><td colspan="2">Patient SS No.:</td></tr>
<tr><td colspan="6">Employer:</td></tr>
<tr><td colspan="2">Patient Income:</td><td colspan="2">Other Family Income:</td><td colspan="2">Total Family Income:</td></tr>
<tr><td colspan="6">Proof of income is necessary for completion of eligibility determination.
Please provide copies of W2, Income Tax returns, paycheck stubs, etc.</td></tr>
<tr><td colspan="3">Fixed Assets $
Fixed Asset – Tangible assets such as property</td><td colspan="3">Liquid Assets: $
Liquid Asset – Easy assessable assets such as cash</td></tr>
<tr><td colspan="2">Liabilities:</td><td>Total Family Members:</td><td colspan="3">Services Rendered/Requested:

Date of Services:</td></tr>
</table>

Department of Health and Human Service Application/Denial Letter or Determination Letter may be accepted in lieu of required information.

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature: ______________________________ Date: ____________