

The documentation checked below is necessary in order to review your application for the uncompensated care program at North Ottawa Community Hospital (NOCH).

EMPLOYABILITY

- If disabled and cannot work, written verification from physician
- Currently or recently receiving unemployment benefits. Written verification of dollar amount and dates of coverage.

ASSISTANCE

- Copy of Medicaid and/or county denial including the reason for the denial.
- Verification of dollar amount and dates of coverage for general assistance, grants, loans, scholarships, etc. from any and all sources.

INCOME

- Complete copy of 2 years of Federal tax return
- Most recent pay stubs

ASSETS

- Copies of most recent checking and saving account statements

ACKNOWLEDGEMENT OF CONSIDERATION

I understand that _____ is being considered for the uncompensated care program at NOCH. This program excludes physician fees and other health care providers or agency fees. This applies to the following accounts only:

<u>Patient No.</u>	<u>Patient Name</u>	<u>Date of Service</u>	<u>Balance</u>
_____	_____	_____	_____
_____	_____	_____	_____

The information provided may be verified or investigated before final determination of eligibility can be made. Failure to provide accurate information or failure to attempt coverage through other available programs will be sufficient cause for denial of consideration under this program.

I further understand that I will be notified in writing of my eligibility under this program.

I, hereby authorize NOCH personnel to confirm the validity of any statements made orally or in writing in this and any other requested documentation.

I understand that any recovery of my losses through legal action or settlement shall entitle NOCH to reimbursement to the extent of any compensation awarded me. I declare that I have read all the questions on this application for uncompensated care and to the best of my knowledge and belief, all of my answers are true, correct and complete.

Date

Signature of Patient or Guardian

Date

Witness



Applicant Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Marital Status: Married Single Widowed Divorced Separated

Number of dependents including self: _____ Social Security No. _____

Spouse Name: _____ Social Security No. _____

Statement of Monthly Income and Expense

Income of all family members:

Gross salaries and wages for household	\$ _____
Government program payments/Social Security	\$ _____
Retirement/Pension Benefits	\$ _____
Workers Compensations/Unemployment Benefits	\$ _____
Child Support/Alimony	\$ _____
Dividends/Interest	\$ _____
Rental/Other (describe) _____	\$ _____

TOTAL INCOME \$ _____

Statement of Assets

Assets:

Cash	\$ _____
Checking Account	\$ _____
Savings Account	\$ _____
Stocks/Bonds	\$ _____
Cash Value of Life Insurance	\$ _____
IRA's	\$ _____
Certificates of Deposit	\$ _____
Real Estate other than primary residence	\$ _____
Automobile (list make, model, year) _____	\$ _____
_____	\$ _____
RV's, etc. (list make, model, year) _____	\$ _____
Boat (list make, model, year) _____	\$ _____
Loans against above <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, list: _____	\$ _____
_____	\$ _____
<input type="checkbox"/> Other _____	\$ _____

NET ASSETS \$ _____