Covenant Financial Assistance Application Form & Information

Revision Date 07/2013

Patient Name: ____________________ MRN: ___________________

Patient Name: ______________________________________ Patient MRN: ____

Head of Household (Guarantor) *if applicable*: ____

Street Address: ____

City: ____ State: ________ Zip: __________ County: ____________________

Home Phone: ____________________ Cell Phone: _______________________ Work Phone: ____________________

Please note one of the following documents as acceptable Proof of Identity. *These should be submitted with your application form.*
- Driver's License - US Passport - School Records (for minors) - Marriage Certificate - Naturalization Certificate

Please note one of the following documents as acceptable Proof of Address *These should be submitted with your application form*
- Driver's License (Current, not expired) - Photo ID card with address (Current, not expired) - Utility Bill for current Month
- Mortgage Statement for current Month

Patient Account Registration Details

(to be completed by the Financial Counselor or Liaison)

Account Reg. #	Date of Admission	Visit Amount	Account Reg. #	Date of Admission	Visit Amount

Application Date: ________________ Total Account Charges: ______________________ Total Balance Due: ______________________
Current Total Balance Due after payments

Household Members

Please provide the full name and date of birth for all members. Please include Social Security Number and relationship, if known. Applicant's Social Security Number, if over 18 years of age, and Date of Birth are required.

Name	Date of Birth	Social Security Number	Relationship to Applicant	US Citizen?
			Self	

Household Income Information

Include all sources of income (wages). Only earned income should be noted here.
All noted income requires proof. Please note the following acceptable forms of verification for Earned Income to the right

Household Member	Employer & Location *(Address if available)*	Amount	Period	Start Date	End Date *(If Applicable)*

Please note the following documents as acceptable Proof of Earned Income
- Paycheck Stubs *(3 pay periods)*
- Letter from Employer *(on Company Letterhead)*
- Tax Return for self employed

Total Household Income – Monthly: ________________

Covenant Financial Assistance
Application Form & Information
Revision Date 07/2013

Patient Name: ____________________ MRN: ____________________

Unearned Income *Unearned income such as Social Security benefits, Alimony, Child Support, Pension, Retirement, etc should be listed here. All noted unearned income requires proper proof. Please provide documentation of verification.*			
Household Member	Unearned Income Type	Amount	Period

Please note the following documents as acceptable Proof of Earned Income
- Statements
- Letters
- Court Documents
- Check Stubs
- Notarized Documents

Total Unearned Income – Monthly: ________________

Assets/Resources *Please provide details about all Assets/Resource for the household.*			
Household Member	Asset/Resource Type	Value	Additional Account Holder(s) *(If Applicable)*

Household Expenses *Please provide details for all current household expense. Please include the monthly totals*					
Type of Expense	Monthly Amount	Period	Type of Expense	Monthly Amount	Period
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

Loan and Installment Payments *Please provide details about all installment payment loans or credit balances due.*					
Type of Expense	Average Payment	Period	Type of Expense	Average Payment	Period

Please note the following documents as acceptable Proof of Assets/Resources as well as Expenses
- Statements
- Letters
- Check Stubs

Covenant Financial Assistance
Application Form & Information
Revision Date 07/2013

Patient Name: ____________________ MRN: ____________________

Health Insurance *Please provide information on any CURRENT health insurance or state program (ie, Medicaid, CHP, Medicare, FHP, etc)* *Please include policy numbers and note which household members are covered if applicable.*				
Policy Holder Name	Policy Name Or State Program Name	Address *(If Known/Applicable)*	Policy Number	Household Members covered under Policy

Please note: All Financial Assistance forms submitted to Covenant HealthCare with the intention of applying for benefits will ONLY cover hospital charges and other professional services provided by Covenant HealthCare physicians. Private room or other personal charges are not covered by the Covenant Financial Assistance program. Cosmetic procedure charges are not covered by the Covenant Financial Assistance program. Elective procedures covered by insurance not accepted by Covenant HealthCare are not covered by Covenant Financial Assistance program.

I affirm that the above information is true, complete, and correct to the best of my knowledge:

Applicant's Signature: ______________________________ Date: ____________________

Authorized Representative Name: ______________________________

Authorized Representative Signature: ______________________________ Date: ____________________

Financial Counselor Name: ______________________________ Phone #: ____________________