DHP DIGESTIVE HEALTH PARTNERS

Charity Care Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Patient ID# _____ Social Security No: _____ Date of Birth: _____

	Person 1	Person 2	Person 3
Monthly Wages/Salary			
Unemployment			
Social Security/Pensions			
Alimony/Child Support			
Other			
Total Income			

	Person 1	Person 2	Person 3
Mortgage/Rent			
Utilities/Cell Phone			
Food/Grocery			
Credit Card/Loans/Car Loans			
Medicines			
Gasoline			
Insurance			
Total Expenses			

DHP DIGESTIVE HEALTH PARTNERS

The following items **MUST** accompany this form in order for your application to be considered. Where applicable, you must include pay stubs from both the patient and the spouse or from the guarantors of any dependent patients.

1. Copies of last two pay stubs as proof of income.
2. Copy of previous year's tax return.
3. Copy of the most recent bank statement with transaction details.
4. Medicaid and/or other state/federal forms, such as disability, as proof of denial or pending status.
5. An application status from CareCredit. Pre-approval without a hard inquiry to the credit report can be processed by CareCredit by using this link https://www.carecredit.com/go/DHC373/
6. Any other documentation to prove that you are unable to pay your medical debt.
7. Documentation from hospital approving financial assistance.

Disclaimer and Signature

I promise that the information written above is true and complete to the best of my knowledge. I understand that this application for medical assistance may be denied if false information is provided. I understand that this is an application only, not a guarantee of assistance. I also understand that this application is confidential and will be protected under HIPAA regulations. I also understand that if approved, the approval is good for the dates of service listed.

.

Signature: _____ Date: _____

For Business Office Use Only:

Approved Assistance? Y/N _____ %

Effective Dates of Assistance _____ to _____
Date Date

_____ _____
Revenue Cycle Manager Signature Date

_____ _____
Revenue Cycle Director Signature Date