Carroll County Memorial Hospital
Application for Financial Assistance (Charity Care)

Patient Name: _____

Address: _____

_____

Home Phone: _____ **Cell Phone:** _____

Patient SSN: _____

Guarantor Name: _____

Address (if different from Patient): _____

_____

Home Phone: _____ **Cell Phone:** _____

Guarantor SSN: _____

Guarantor Employer: _____

Address: _____

_____

Work Phone: _____

Number of Household Members Living at Home: _____

Please list Name, Age & Relationship of Each Household Member:

_____

_____

_____

_____

Monthly Income Verification

- Patient's Income (or parent's, if patient is a minor): _____
- Spouse's Income: _____
- KTap: _____
- Child Support/Alimony: _____
- Social Security: _____
- SSI/Disability: _____
- Unemployment: _____
- Pension: _____
- Food Stamps: _____
- Other Income? IF yes please list: _____

Total Monthly Income: _____

Monthly Expenses Verification

- Rent/Mortgage: _____
- Food/Supplies: _____
- Clothing: _____
- Utilities: _____
- Telephone: _____
- Childcare: _____
- Hospital Insurance Premiums: _____
- Prescription Expenses: _____
- Other Expenses? IF yes please list: _____

Total Monthly Expenses: _____

Resources:

- Checking/Savings Accounts – Current Balance: _____
- Stocks/Bonds – Current Value: _____
- Other Resources? IF yes please list: _____

Total Resources: _____

Property:

Home Mortgage Name: _____

Address: _____

_____

Current Value/Equity: _____

Auto #1 Information:

Year/Make/Model: _____

Owner: _____

Current Value/Equity: _____

Auto #2 Information:

Year/Make/Model: _____

Owner: _____

Current Value/Equity: _____

Other Property/Autos? IF so, please list:

_____

_____

_____

_____

Medical Expenses – Please list by facility/physician name & balance:

_____

_____

_____

_____

Responsible Party Name: _____

Monthly Income:

- **Guarantor's Gross Income:** _____
- **Spouse's Gross Income:** _____
- **Other Income:** _____

Total Family Income: _____

Family Size:

Current Charity Care Guidelines – net monthly income eligibility standards

FAMILY SIZE (MONTHLY INCOME)

DISCOUNT	1	2	3	4	5	6	7	8
100%	$1,041	$1,703	$2,152	$2,600	$3,048	$3,497	$3,945	$4,393
90%	$1,145	$1,873	$2,367	$2,860	$3,353	$3,847	$4,340	$4,833
80%	$1,260	$2,060	$2,604	$3,146	$3,688	$4,232	$4,774	$5,316
70%	$1,386	$2,266	$2,864	$3,461	$4,057	$4,655	$5,251	$5,847
60%	$1,525	$2,493	$3,150	$3,807	$4,463	$5,121	$5,776	$6,431
50%	$1,678	$2,743	$3,465	$4,187	$4,910	$5,633	$6,354	$7,074
40%	$1,846	$3,017	$3,811	$4,606	$5,401	$6,196	$6,989	$7,781
30%	$2,031	$3,319	$4,192	$5,067	$5,941	$6,816	$7,688	$8,559
20%	$2,234	$3,651	$4,611	$5,574	$6,535	$7,498	$8,457	$9,415
10%	$2,457	$4,016	$5,072	$6,131	$7,189	$8,248	$9,303	$10,356

100% Discount based on 2024 Federal Poverty Guidelines

Source: aspe.hhs.gov/poverty-guidelines

This certifies that I request to be considered for financial assistance at Carroll County Memorial Hospital (CCMH). I agree to furnish CCMH with any information necessary to determine my eligibility for assistance with medical bills resulting from the services I have received at CCMH. I understand that failure to complete and return this requested information within 30 days may result in the denial of my request for assistance.

I certify that the information provided by me in this application is correct and true to the best of my knowledge and belief. I understand that if I give false information or withhold any information in applying for this assistance, my application will be denied and CCMH will continue to pursue collection of any outstanding balance due. In that instance, I may also be subject to prosecution for fraud. I also agree to notify CCMH of any changes to the information provided in this form including address, telephone number and/or income.

_____ _____

Responsible Party Signature Date

_____ _____

Witness Date

Questions concerning your application? Please note below. Thank you!

_____

_____

_____

_____

_____

_____