WVU Medicine
JACKSON GENERAL HOSPITAL

MHHC
Morad/Hughes Health Center

PO Box 720, 122 Pinnell St. Ripley WV 25271

Application for Charity Care

Name: _____ SS# _____
Last First Middle

Date of Birth _____ Phone # (304) _____

Address: _____
Street City/State Zip Code

Employer _____ Employment Status _____ How long Employed_____

Employer Address _____ Emp. Phone: _____

ALL INFORMATION PROVIDED IS CONFIDENTIAL

Patients Gross Income _____

Other Family Income _____

Total Family Income _____

Family Size _____ Ages: _____

Bank: _____

Account Type _____ Balance _____

Account Type _____ Balance _____

Account Type _____ Balance _____

Own Home _____ Buying _____ Mortgage Balance _____

Rent _____ Rent Amount _____

Other Assets _____ Value _____

_____ Value _____

Auto # 1: _____ Amount Owed _____
Make Year

Auto # 2: _____ Amount Owed _____
Make Year

Recreational Vehicles Owned: _____ Amount Owed _____
(boat, motorcycles, atv, campers, etc.) Make Year

(Please attach proof of income; tax return,payroll check stub and bank statement)

I certify that the above information is true and accurate to the best of my knowledge. I authorize Jackson General Hospital (JGH) to verify it's accuracy. I further authorize the employers/institutions to release such information to JGH. 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 reasonable 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.

Date of Request _____ Applicant's Signature _____

Applications will not be processed without proof of income for all household members and a Medicaid denial letter for each uninsured patient seeking Financial Assistance.

ELIGIBILITY DETERMINATION *(For Office Use Only)*

Date Application Received: _____

Type of Verification:

Income Verified: _____ Employer Verification
_____ Payroll Stubs
_____ Income Tax Return
_____ Bank Account(s)
_____ Social Security Benefit
_____ 3 Notarized Letters

Budget Analysis:

INCOME
Gross Income:
Other Income:
TOTAL:
ASSETS
Home
Auto
Recreational
Other
TOTAL ASSETS:

The applicant's request has been:

Approved _____ Denied _____ Reason:_____

Date Applicant Notified _____ Approved By _____

Amount approved for Charity:
IP/OP/ER/MHHC Original Patient Account (s) Date of Service

Charity Approved Effective Dates of Service _____