

**Application for Free or Reduced-charge services under the ICTF Program**

Patient: \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_  
 Name of Applicant: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Accounts & Charges: \_\_\_\_\_  
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*\*\*\*Please provide household members names and proof of income for the past 90 days, in which the application should be applied. If you are unemployed and have no income please indicate zero income. Proof of income can be the most recent check stubs for the past 90 days, an income tax return. If income of any member is from self-employment, you may give information on business costs so that we can determine actual income to be counted. Proof of residency also required. Please include comments/details on the back of this application. \*\*\**

Name of Person(s) in Household	Birthdate	Relationship	Income week	Income month	Income year	Total Income
1						
2						
3						
4						
5						

*\*\*\*You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you live with a relative and that person is not responsible for paying your medical bills, their income would not have to be counted. \*\*\**

MONTHLY EXPENSES		
Rent/Mort:	Water:	Car payment:
Electric:	Loans:	Credit cards:
Other:		
<i>(Other would include but not limited to convenience items such as cable TV; internet, etc)</i>		

Has applicant exhausted all other third-party payer options, third-party liability options or financial assistance options, prior to being considered for Indigent/Charity Care. YES \_\_\_\_\_ NO \_\_\_\_\_

**I certify that the above information is true and accurate to the best of my knowledge.**

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\***For Hospital Staff**\*\*\*\*\*

Number counted in household: \_\_\_\_\_ Total Countable Income: \_\_\_\_\_  
 (Average monthly income for last year or past 3 months, whichever is more favorable)

Verification of income supplied (if required) Yes \_\_\_\_\_ No \_\_\_\_\_  
 Determination: Eligible for free services \_\_\_\_\_ Conditional \_\_\_\_\_ Pending \_\_\_\_\_  
 Eligible for discounted services: \_\_\_\_\_ % \_\_\_\_\_ Conditional \_\_\_\_\_ Pending \_\_\_\_\_  
 Ineligible \_\_\_\_\_ Reason \_\_\_\_\_

Date notice mailed: \_\_\_\_\_ Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reconsideration: \_\_\_\_\_  
 Result: \_\_\_\_\_ Date: \_\_\_\_\_