

SHARON REGIONAL HEALTH SYSTEM

APPLICATION FOR CHARITY CARE

*Please complete front and back. Return by _____
to Sharon Regional Health System, Business Office, 699 E. State St., Sharon, PA, 16146-2096
Phone: (724) 983-3820 or (800) 950-9981*

PATIENT NAME: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____
GUARANTOR NAME: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____

Soc Sec No: _____
Home Phone: _____
Soc Sec No: _____
Home Phone: _____

DEPENDENTS

NAME	RELATIONSHIP TO GUARANTOR	SOC.SEC.#	AGE	(Full time students) NAME OF SCHOOL

** Please attach a separate paper if additional space is required.*

TOTAL NUMBER IN FAMILY UNIT (Including patient and guarantor): _____

APPLICATION WILL NOT BE PROCESSED WITHOUT PROOF OF ALL INCOME AND DISCLOSURE OF ALL RESOURCES, ASSETS AND LIABILITIES.

GUARANTOR

Employed by: _____
Address: _____
Phone: _____ Length of Employment: _____
Hrs Worked per pay _____ Gross Income:\$ _____ Monthly _____ Weekly _____ Biweekly _____

OTHER

Name: _____
Employed by: _____
Address: _____
Phone: _____ Length of Employment: _____
Hrs Worked per pay _____ Gross Income:\$ _____ Monthly _____ Weekly _____ Biweekly _____

OTHER INCOME: *(Include social security benefits, pensions, welfare, unemployment or workers compensation, alimony, child support, disability from employer, rental income etc.)*

Source of Income: _____ Monthly Gross:\$ _____
Source of Income: _____ Monthly Gross:\$ _____
Source of Income: _____ Monthly Gross:\$ _____

TOTAL GROSS MONTHLY INCOME:\$ _____

List health insurance coverage you have had within the past six months: _____
If employed full time, does your employer offer health insurance? YES _____ NO _____
Do you have Major Medical coverage? YES _____ NO _____ If yes list: _____
Have you applied for State Medical Assistance within the past six months? YES _____ NO _____

ASSETS

TYPE	HOLDER	BALANCE/VALUE
Checking Account	_____	\$ _____
Savings	_____	\$ _____
Rental Property	_____	\$ _____
Other (example:401K,CDs,IRAs,etc.)	_____	_____

LIABILITIES

TYPE	TO WHOM INDEBTED	CURRENT BALANCE	MONTHLY PAYMENT
Mortgage / Rent	_____	\$ _____	\$ _____
Auto Loan	_____	\$ _____	\$ _____
Personal Loan	_____	\$ _____	\$ _____
Credit Cards	_____	\$ _____	\$ _____
Other (please describe)	_____	_____	_____

I hereby grant Sharon Regional Health System permission to investigate my financial status and run a credit report, if necessary, for the purpose of ascertaining my eligibility for Sharon Regional Health System's Charity Care Program for assistance with payment for services provided therein. I certify that to the best of my knowledge all information listed is true and correct.

APPLICANT : _____ DATE: _____
 (Signature)

PLEASE NOTE: The Charity Care Program applies only to self-pay bills for hospital services provided at SRHS. Hospital bills assigned to a debt collection agency are not eligible for consideration. Bills you may owe to your physician, surgeon, cardiologist, radiologist, ER physician, anesthesiologist, or for other medical services, such as prescription medications or ambulance services, cannot be adjusted through this program.

(Office use only)

STATUS: _____ Denied or _____ Approved at _____ %

ACCOUNT NO.	BALANCE
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
TOTAL:	\$ _____

Submitted: _____ Date: _____ Approved: _____ DATE: _____
 (Initials)

Comments: _____

