The Hospitals of PROVIDENCE

Indigent Care Application

Applicant Information

Patient Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: ( ) _____ Social Security Number: _____

Date of Birth: _____ ☐ Male ☐ **Female**

Person submitting application: _____

Relationship: _____

Marital Status: ☐ **Married** ☐ **Single** ☐ **Widowed**

Spouse Information (If Applicable)

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

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: ( ) _____ Social Security Number: _____

Date of Birth: ☐ Male ☐ **Female**

Household Information

I and or my spouse receive public assistance: ☐ **Yes** ☐ **No** **Type:** _____

Please list all dependents in household under 21 years of age

Name	Date of Birth	Relationship

Income Information

Are you currently employed? ☐ **Yes** ☐ **No** **If yes, what is your monthly income?** _____

Is your spouse currently employed? ☐ **Yes** ☐ **No** **If yes, what is your monthly income?** _____

Please check any other income that you receive.

☐ Social Security
☐ Veterans Benefits
☐ Pension
☐ Unemployment
☐ Support Payments
☐ Disability
☐ Rental Property
☐ Other

Additional Monthly income total: _____

Additional Information

Health Insurance Carrier: _____ **ID #** _____

Insured Name _____ **Group #** _____

Emergency Room Benefits:

Deductible: _____

Coinsurance: _____

Visit Information

Date of Service: _____

Reason for your visit: _____

Diagnosis: _____

Amount covered by insurance: _____ Amount paid by patient: _____

Please provide the following information:

1. Please list monthly expenses (rent, mortgage, utilities, etc.)

Expense	Amount	Expense	Amount	Expense	Amount

2. Please list and explain any relevant medical expenses that you currently have and attach copies of bill

Expense	Amount	Expense	Amount	Expense	Amount

3. Please use the following space to explain your situation further if necessary.

I understand The Hospitals of Providence may verify the financial information contained in this application in connection with the evaluation of this application, may contact my employer to certify the information provided, and may request reports from credit reporting agencies. I am aware this information is used to determine my eligibility for financial assistance. I agree The Hospitals of Providence may contact these sources to update the information at any time. I am aware that falsification of information on this application may result in denial of financial assistance.

_____

Printed Name

_____ _____

Signature Date