APPLICATION FOR GSH MEDICAL INDIGENT PROGRAM

PATIENT NAME mi_____

STREET ADDRESS _____

CITY, STATE_____**PHONE #**_____

ACCOUNT #_____

Please complete the following information below:

A. **How many people comprise the family unit?**

Patient/Self	_____
Spouse	_____
Number of Legal Dependants	_____
Other _____	_____
Total	_____

B. **Is the primary wage earner(s) (Whom) in your household Disabled, Retired, or will be retiring within the next 12Months? Date?**

C. **Is the primary wage earner(s) (Whom) in your household unemployed due to factors beyond the control and not related to seasonal employment? How long? Reasoning for Unemployment?**

D. **Does any member of your household require extensive Inpatient or Outpatient care? Does any member of your household have excessive prescriptions or medical supply expenses? (Documentation needs to be provided).**

E. **Is any member of the family covered by health insurance now? Yes or No** ☐ ☐

F. **Did anyone in your household who does not have health insurance lose their coverage in the last 3 months? Yes or No----If Yes, Who and When did coverage end?** ☐ ☐

G. **If insurance coverage was lost please provide us the reasoning why?**
(Please mark what applies)
Loss of employment ☐ **Coverage Limit Reached** ☐ **Divorce** ☐
Non-custodial parent dropped insurance ☐ **Could Not Afford** ☐
Company ended Coverage ☐ **Other Specify**_____

H. **Was the Household income in the prior 3-months the same as it is now? Yes or No** ☐ ☐
If no, please explain:

I. Please provide us how much work income you and other members of your family make.

Name of person working_____ Start Date_____ End Date_____ Amount of gross pay per period_____ How often Paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a Month ☐ Other Hours worked a week____ Do hours vary? ☐ Yes ☐ No Is person self-employed? ☐ Yes ☐ No	Name of person working_____ Start Date_____ End Date_____ Amount of gross pay per period_____ How often Paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a Month ☐ Other Hours worked a week____ Do hours vary? ☐ Yes ☐ No Is person self-employed? ☐ Yes ☐ No

J. Is there any other Income for your household? (Please mark that apply):
(Documentation needs to be provided)
Social Security ☐ **Pension** ☐ **Support (Alimony or Child)** ☐
Food Stamps/TANF ☐ **Cash from Friends,Relatives, etc.** ☐ **Retirement** ☐
Property ☐ **Workers Compensation** ☐ **Unemployment** ☐
Stocks ☐ **Bonds** ☐ **CD's** ☐ **Savings Account** ☐

K. NOTE SECTION:
Please be very descriptive of patient/family financial situation:

Application Taken By_____Date_____

Rv7-1-04rk