JOHNSON MEMORIAL HEALTH SERVICES
REQUEST FOR FINANCIAL ASSISTANCE (Charity Care)

It is the policy of Johnson Memorial Health Services, to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon the family/household size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic and ER, but not those services which are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services.

If you have any questions, please call our Patient Account Representative at 320-312-2136

This form must be completed every 6 months or if your financial situation changes.

Name		**Date of Birth**		
Street	**City**	**State**	**Zip**	**Phone**
Health Insurance Plan		**Social Security Number**		

Charity Care Application	**YES**	**NO**
I have been offered and understand the Charity Care process, but choose to decline these services.	☐	☐

- **If you chose Yes, to the answer above, please disregard the MA and income verification questions and sign and date at the bottom of the page. If you chose No, please fill out the rest of the application and return with the required documentation.**

In order to qualify for the Charity Care program, you must apply for Medical Assistance in your county first.

Have you applied for Medical Assistance with your county? Yes___ No___ (please check one)

If No, you must do so.

If Yes, what was the outcome? (If denied, attach copy of denial)_____

Verification Checklist (attach copies)	**YES**	**NO**
Income: Prior year tax return	☐	☐

I certify that the information shown above is correct.

Name (Print):	**Date:**
Signature:	