optim medical center | SCREVEN

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:		
*(**Other** would include but not limited to convenience items such as cable TV; internet, etc)*		

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: _____

***HOSPITAL BASED CLINIC/HOSPITAL INPATIENT, REGULAR OP, and EMERGENCY DEPT PATIENTS**: If approved, this application is valid for services 30 days prior to the day the application is approved and for a period of 6 months following the approval date*