Charity Care Application
Coal County General Hospital
dba Mary Hurley Hospital

Name of Patient:_____ SSN:_____

Name of Spouse:_____ SSN:_____

Name of person responsible for the bill: _____

Number of dependents:_____ Phone number:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Employer: _____

Employer Address: _____

State: _____ Zip Code: _____ Employer Phone Number: _____

Spouses's Phone Number: _____

Spouses's Employer: _____

Address: _____

State: _____ Zip Code: _____ Employer Phone Number: _____

Monthly Household Income: ***Income includes wages, annuities, social security, retirement benefits, unemployment, worker's compensation, child support or alimony. This list is not all inclusive***	
Source	***Amount***
	$
	$
	$

If you have reported $0 income, please provide a brief explanation of how you (or the patient) are surviving financially:

Liquid Assets		
Accounts	***Name of Institution:***	**Balance**
Checking		**$**
Savings		**$**
Other		**$**

Charity Care Application
Coal County General Hospital
dba Mary Hurley Hospital

Other Assets and Liabilities			Monthly Payment
Do you own your own home?	Yes ☐	No ☐	$
Do you lease or rent your home?	Yes ☐	No ☐	$
Name of Landlord _____			
Are you leasing/paying on a vehicle?	Yes ☐	No ☐	$

Utilities	Average Monthly Payment
Electrical/Gas	$
Water	$
Telephone	$
Cable or Satellite TV	$

Credit Card Name	Payment	Balance
	$	$
	$	$
	$	$
	$	$

Other Debts		
To Whom Owed	Payment	Balance
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

Before your application can be processed, you must provide the following documentation to our Patient Accounts Representative:

_____ Completed charity application.

_____ Most recent federal/state income tax returns for all family members living at home

_____ Paycheck/unemployment check stubs for the past three months, or a written statement of earnings from employer(s).

_____ Statements of monthly benefits from social security income.

_____ Denial received from Department of Human Services (DHS) Medicaid program.

_____ Car payment book or monthly statement, if applicable.

Charity Care Application
Coal County General Hospital
dba Mary Hurley Hospital

I hereby certify that I am of legal age and that the foregoing statements are true and complete and are made for the purpose of determing my eligibility for Charity Care at Coal County General Hospital, Inc., dba Mary Hurley Hospital. I agree that this statement shall remain hospital property, whether or not the application is accepted. I agree to provide all required information. I authorize you to make all inquires that you deem necessary to verify the accuracy of the statements made herein. I understand that if I give any false information in the application, I will be denied Charity Care Services.

Applicant's Signature:_____

Spouse's Signature: _____

Date: _____