UNION GENERAL HOSPITAL
APPLICATION FOR
CHARITY CARE ASSISTANCE
EXHIBIT A

Please complete the following application to determine eligibility for the Union General Hospital Charity Care Program. The Hospital will assist patients with the completion of an application for Medicaid benefits where applicable. If you do not qualify for Medicaid, please attach a copy of your letter of "Notice of Decision on Your Medical Assistance Application" from the Medicaid Program or if your services are not covered by the Medicaid Plan (take charge). Patients with commercial insurance may apply for charity application only if they have a pending deductible of $5,000 or more.

If you have any questions or need assistance completing the application, please call the Business Office at Union General Hospital.

Completed applications should be submitted to the Business Office Manager at Union General Hospital.

GENERAL INFORMATION

Applicant's Name: ____________________ ____________________ ______
(Please Print) (Last Name) (First Name) (MI)

Social Security Number ____________________

Address: ______________________________

City: ______________________________ State: _____ Zip Code: ____________

Parish of Residence: ____________________ **(must be resident of Union Parish)**

Home Phone: ____________________ Work Phone: ____________________

Date of Birth: __/__/____ Sex: ______ Marital Status: ____________________

Number of members in household: ____________

Employment Information

Applicant Employer (or most recent employer)	Spouse Employer (or most recent)
Employer Name: ____________________	Employer Name: ____________________
Address: ____________________	Address: ____________________
____________________	____________________
Phone #: ____________________	Phone #: ____________________

Has a Medicaid application been completed? ___________ (If patient/guarantor does NOT qualify for Medicaid, please attach a copy of the Medicaid Denial Letter to this application or documentation that services not covered (N/A if take charge coverage only OR N/A if non-coverage)

Does patient have commercial insurance? _________ (If patient does have commercial insurance, we must have documentation showing that deductible is over $5,000 and patient's out of pocket will be in excess of $1,000.

Provide two (2) most recent year's W-2 and IRS Form 1040 Income Tax Return
Information provided? (N/A if screening mammogram. Any patient without insurance coverage meets charity care plan for write of technical component mammogram) _________

Provide Proof of residency (At least one recent utility bill)
Information provided? __________

I understand that the information that I submit is subject to verification by Union General Hospital. I certify that the information provided as part of this Application for Charity Care Assistance is true and correct to the best of my knowledge.

Applicant Signature: ______________________________

Date: ______________________________

*Please be sure to include all requested information before submitting your application. The application will not be processed if all requested information is not included.

For Union General Hospital use only

Does the applicant qualify for Charity Care assistance? ___________

If YES, $ balance of Patient Account: $ ___________ Pt Acct(s)# _____________

Screening Mammogram: _____ Yes/No

UGH Authorized Signature: _______________________ **Date:** ___________