Request for Determination of Eligibility for Uncompensated Services

☐ New ☐ Renewal Date of Request: _____

As provided for in Federal Law, I hereby request that Falls Community Hospital and Clinic (FCHC) make a written determination of my eligibility for uncompensated medical services at a FCHC facility.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Occupation: _____ Employer: _____

	Total for Last 3 months	Total for Last 12 months	Copies of:	Verbal
Wages				
Farm or Self-Employed				
Social Security Check				
Public Assistance				
Unemployment Compensation				
Worker's Compensation				
Child Support				
Pension				
Other Income				
TOTAL INCOME:				

Enter Number in Family _____

Family Size	100% of Income	200% of Income
1	$12,060	$24,120
2	$16,240	$32,480
3	$20,420	$40,840
4	$24,600	$49,200
5	$28,780	$57,560
6	$32,960	$65,920
7	$37,140	$74,280
8	$41,320	$82,640
****Each additional person	$ 4,180	$ 8,360

A family unit may include only immediate family members including the Mother, Father, and children. All friends and/or relatives living in the same household will be considered as separate family units.

I affirm that the above information is true and correct to the best of my knowledge. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by FCHC. I also understand that if the information which I submit is determined to be false, such as determination will result in the denial of my eligibility for uncompensated services and I will be liable for services provided.

Applicant Signature: _____ Date: _____

Request for Determination of Eligibility for Uncompensated Services continued.....

EXPIRES:

Total household income for last 3 months: $ x 4 = $

Or

Total household income for last 12 months: $

Number of persons in household:

Name/DOB	Relationship
	Self

List additional names on the back of the page

Based on the information received the patient is: ☐ Eligible ☐ Ineligible

Signature of person making determination: Date:

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* I understand that I must pay a $40.00 co-pay for each clinic visit before services are received. Also, ther will be a $40.00 co-pay for emergency room visits.

* I understand that the radiologist charges for reading x-rays, and all send out labs will be the patient's responsibility.

* I understand that it is my responsibility to inform Falls Community Hospital of any substantial change in income.

* I understand that this application will expire 3 months (90 days) from the date of determination. I also understand that to continue to receive benefits, I must reapply and meet the charity guidelines.

* I understand that if the information which I submit is determined to be false, such a determination will result in the denial of my eligibility for uncompensated services and I will be liable for services.

* I understand that to receive benefits I must present this card at the time of admission. This applies to the Emergency Room, Inpatient services, Outpatient services, and Clinic visits.

Applicant Signature Date: