Jefferson Health

Jefferson Health Compassionate Care
Application Form & Information

Patient Name: _____ MRN: _____

Patient First Name: _____ Last Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Head of Household Name *(if applicable)*: _____ Relationship to Patient: _____

Patient Home Phone: _____ Patient Cell Phone: _____

Patient Work Phone: _____ Patient Email: _____

Please confirm the address above. Please correct if needed.

Household Members*

Please provide the full name and date of birth for all members. Please include Social Security number and relationship.

Name *Full Name – First Name, MI, Last Name*	**Date of Birth**	**Social Security Number**	**Relationship to Applicant**	**Applying** Check if Yes
			SELF	❒
				❒
				❒
				❒

Relationship to Applicant should be the relationship of the Household Member to the applicant, not the Guarantor. Examples would be wife, husband, daughter, son, mother, father, step-son, step-daughter, cousin, etc.

*If more household members than those listed above, please see last page for extensions

Household Income*

Please indicate if you or anyone in your household receives any of the following types of income:

❑ Wages/Salary
❑ Self-Employed
❑ Social Security
❑ Child Support
❑ Alimony
❑ Unemployment Compensation
❑ Pension
❑ Real Estate/Rental Property Income
❑ Veteran's Benefits
❑ Disability/Disability Benefits
❑ Workmen's Compensation
❑ Student I-20
❑ Other

Please provide the following information for all incomes you have indicated are received:

Household Member	**Type** *Provide Employer Name if Applicable.*	**Amount**	**Period** *Select one.*	**Start Date**	**End Date** ***(If Applicable)***
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		

*If more household income than those listed above, please see last page for extensions

For all household income received, you must provide supporting documents from the past 30 days in order to complete this application. (i.e., tax return, pay stubs, approval letter(s), self-employment schedules, child support statements, etc.)

❑ My household does not have any earned or unearned income

Assets/Resources*

Patient Name: _____ MRN: _____

Please indicate if you or anyone in your household receives any of the following resources:

❑ Checking Account(s) ❑ CD(s) ❑ Mutual Funds
❑ Savings Account(s) ❑ Annuities ❑ Other
❑ Money Market Account(s) ❑ Bonds

Please provide the following information for all assets/resources indicated:

Household Member	Type	Account Number	Value

*If more assets/resources exist than those listed above, please see last page for extensions

For all asset(s)/resource(s) indicated, you must provide proof from the past 30 days.

❑ My household does not have any assets or resources to claim.

Other Information*

Please answer the following questions.

Does patient have a permanent resident card for the United States? ❑ Yes ❑ No

Does this household currently have public assistance? ❑ Yes ❑ No *If yes, provide the following:*
Insurance Company Name & ID number: _____

Has patient applied for public assistance in the last 12 months? ❑ Yes ❑ No
If yes, were you denied coverage ❑ Yes ❑ No
Please attach approval/denial PA-162 letter. *(Received from the PA Dept. of Welfare)*

Does patient have health insurance? Should you receive health insurance, please notify the department. Health Insurance is always primary over financial assistance. ❑ Yes ❑ No *If yes, provide the following:*

Insurance Company Name & ID number: _____

Insured's Name: _____Birthdate: _____/_____/_____
_____

*If more information to be noted than that listed above, please see last page for extensions

Is the patient eligible for any of the following? ❑ Yes ❑ No
❑ Subsidized School Lunch Program ❑ Low Income Subsidized Housing
❑ State Funded Prescription Program ❑ WIC ❑ Food Stamps
If **YES** to any of the above, please provide documentation verifying eligibility

Signature

I affirm that the above information is true, complete, and correct to the best of my knowledge:

Applicant's Signature: _____ Date: _____

OR

Authorized Representative Signature: _____ Date: _____

Authorized Representative Name: _____ Relationship to Applicant: _____

Authorized Representative Phone #: _____ Cell #: _____

Patient Name: _____ MRN: _____

Household Members (continue) *Please provide the full name and date of birth for all members. Please include Social Security number and relationship if known.*				
Name *Full Name – First Name, MI, Last Name*	**Date of Birth**	**Social Security Number**	**Relationship to Applicant**	**Applying** Check if Yes
				❒
				❒
				❒
				❒
Relationship to Applicant should be the relationship of the Household Member to the applicant, not the Guarantor. Examples would be wife, husband, daughter, son, mother, father, step-son, step-daughter, cousin, etc.				

Household Income (continued)					
Please provide the following information for all incomes you have indicated are received:					
Household Member	**Type** *Provide Employer Name if Applicable.*	**Amount**	**Period** *Select one.*	**Start Date**	**End Date** ***(If Applicable)***
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		

🖹 For all household income received, you must provide supporting documents from the past 30 days in order to complete this application. (i.e., tax return, pay stubs, approval letter(s), self-employment schedules, child support statements, etc.)

Assets/Resources (continued)			
Please provide the following information for all incomes you have indicated are received:			
Household Member	**Type**	**Account Number**	**Value**

🖹 For all asset(s)/resource(s) indicated, you must provide proof from the past 30 days.

Other Information (continued)

Please answer the following questions.

Does patient have any additional health insurance? Should you receive health insurance, please notify the department. Health Insurance is always primary over financial assistance. ❑ Yes ❑ No *If yes, provide the following:*

Insurance Company Name & ID number: _____

Insured's Name: _____Birthdate: _____/_____/_____