COMMUNITY FINANCIAL ASSISTANCE APPLICATION (CFA-3)

(For Hospital Use Only)

FIN #s: ______

Dept: ______

Who Requested: ______

Network Service Location

(For Hospital Use Only)

Date: ______

Approved 100% ☐ 80% ☐ 60% ☐ 40% ☐ 20% ☐

Pending ☐ Denied ☐

Signature: ______

I understand that Community Financial Assistance is awarded after Mary Free Bed conducts clinical and financial review, and may or may not be approved based on this review. I understand that the information provided in this application is subject to verification by Mary Free Bed. I also understand that if the information provided is determined to be false, my application for assistance may be denied and the account balance due will remain my responsibility.

SECTION ONE: PATIENT INFORMATION

Patient Name:	Dates of Service(s):	Date of Birth:
Street Address:	Home Phone:	Primary/Cell Phone:
City/State/Zip:	Social Security Number:	
Mailing Address (If different):		
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other	Are you a legal resident of the United States? ☐ Yes ☐ No	Did you have health insurance or any other coverage at the time of your service? ☐ Yes ☐ No
Do you file a Federal Tax Return? ☐ Yes ☐ No If No, why? ______	Who is the primary filer? ☐ Self ☐ Spouse ☐ Other	Does anyone in the home receive public assistance? ☐ Cash ☐ Food ☐ Other ______

SECTION TWO: APPLICATION

Do you have health insurance?	☐ Yes	☐ No	If Yes, Name/ID:
If No, did you apply for insurance through the Health Insurance Marketplace?	☐ Yes	☐ No	Please select reason enrollment was not completed and provide documentation if available ☐ I did not qualify ☐ I cannot afford the premium ☐ I am exempt from penalties ☐ Other – please include letter of explanation with application
Do you have Medicaid?	☐ Yes	☐ No	If Yes, please provide the Medicaid ID number, sign and date on page three and submit this document to Mary Free Bed for review. No additional documentation is necessary at this time.
If No, have you applied for Medicaid?	☐ Yes	☐ No	
Do you receive assistance with medical bills? (i.e; Amish, County Health Dept., Church, Indian Reservation, Sliding-fee Scale)	☐ Yes	☐ No	If Yes, Name/ID:
Do you have Medicare?	☐ Yes	☐ No	If Yes, Name/ID:

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Is anyone in the household a veteran?	☐ Yes	☐ No	If Yes, Name:
Is there a member of the household who became unemployed within the past 90 days?	☐ Yes	☐ No	If Yes, Name:
Were health benefits received by this person?	☐ Yes	☐ No	If Yes, Name of insurance company:

If you answer **Yes** to any of the any of the questions below, you will need to apply for Medicaid before being eligible for Financial Assistance

Are you under 21 years of age?	☐ Yes	☐ No	
Are you 65 years of age or older?	☐ Yes	☐ No	
Are you pregnant now or have you been in the last 3 months?	☐ Yes	☐ No	
Are you blind or disabled?	☐ Yes	☐ No	
Are you a parent or close relative living with and acting as a parent for a child under the age of 18?	☐ Yes	☐ No	

SECTION THREE: HOUSEHOLD MEMBERS / Please provide the following for all household members

Name:	Date of Birth:	Relationship to Patient:	Is this person listed on your Federal Tax Return?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

SECTION FOUR: HOUSEHOLD ASSETS (List assets for all household members)

Asset Source	What household member owns this asset?	Current Asset Value	Asset Source	What household member owns this asset?	Current Asset Value
Checking Account					
Checking Account #2			Other:		
Savings Account					
Savings Account #2					
HSA/FSA					

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SECTION FIVE: EMPLOYMENT				
Person Employed	**Employer**	**Gross Pay**	**Per:**	**Monthly Gross:**
			☐ Wk ☐ 2Wk ☐ Month	
			☐ Wk ☐ 2Wk ☐ Month	
			☐ Wk ☐ 2Wk ☐ Month	

SECTION SIX: MONTHLY HOUSEHOLD INCOME FROM OTHER SOURCES		
Source	**Monthly**	**Annually**
Child Source/ Alimony	$	$
Federal Assistance Program Type _____________________ (i.e. Cash, Food Stamps, etc.)	$	$
Pension / IRA / 403(b) / Annuity Cashout	$	$
Social Security / Social Security Deposit	$	$
Unemployment or Worker's Comp (Start Date: MM/DD/YY End Date: MM/DD/YY	$	$
Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)	$	$
Total Monthly Gross Income from Other Sources	$	$

END

I hereby affirm that the above information is correct to the best of my knowledge. I authorize Mary Free Bed to verify any information for completeness and accuracy. I further authorize such information to be available for release to Mary Free Bed.
I certify my typed name (below) represents my signature and signifies my consent.

SIGNATURE ______________________________ **DATE** ______________

PATIENT REPRESENTATIVE SIGNATURE ______________________________ **DATE** ______________
(if applicable)