HOPE Program Application

Helpful Options for Patient Expenses

Last Name First Name Middle Initial

Address City State Zip

Phone _____ Emergency Contact Outside of Household _____ Phone _____

Monthly Household Income	Applicant Social Security #	Spouse/Other Social Security #	Other Social Security #
Current Gross Wage/Salary	$	$	$
Self Employment Income	$	$	$
Social Security/Disability	$	$	$
Unemployment	$	$	$
Child Support, Alimony etc.	$	$	$
Other Income	$	$	$
Other Income	$	$	$
*include all income of each family member included in household			

Attach copies of last two (2) years Federal Tax Returns or proof of other income(s)
Your application will not be processed without income verification

Number of Children living in Household [ ] Names & Ages _____ _____

_____ _____ _____

I certify that the information provided is true and accurate. I will make applications and/or take necessary actions to obtain any assistance (Medicare, Medicaid, General Medical Assistance, liability insurance, etc.), which may be available for the hospital services received. I will also assign or pay to the hospital any amount recovered for hospital services not to exceed the benefit provided with this application.

The HOPE program is based upon current federal poverty guidelines and family size. The Community Medical Center, Inc. does reserve the right to request additional financial information to assist in the determination of eligibility for HOPE benefit. I understand this application will be used to determine my eligibility for uncompensated charity services provided by the Community Medical Center, Inc. and all information requested must be provided.

If any information that I have provided proves to be misrepresented, I understand Community Medical Center, Inc. will take appropriate actions to obtain payment not to exceed the benefit initially provided. I understand that as part of the review process that a credit report may be obtained to verify my financial resources. All information obtained will be kept confidential and will be protected under the patient's rights to privacy.

_____ _____
Signature of Applicant Date

Applications will not be processed until 1) eligibility for HHS assistance is determined and 2) income verification for all household members is received. Community Medical Center, Inc. reserves the right to deny HOPE benefits to any applicant who does not submit a complete application within thirty (30) days of discharge, date of service or first notification of a private-pay balance."

Date Received _____ by _____ Date Completed _____