BRIGHTSPRING®
HOSPICE FOUNDATION

# CHARITY CARE FORM

**DATE:** _____ **PATIENT NAME:** _____ **MR#:** _____

**Please provide any of the following items that are applicable in order to confirm family monthly income/Reserves:**

- ☐ Most recent Federal / State income tax forms
- ☐ Unemployment check stubs/paycheck (3mths)
- ☐ Statement of monthly benefits from SS
- ☐ Life insurance policy documentation
- ☐ Documentation of other investment accounts
- ☐ Documentation/statement of other assets/estate
- ☐ W-2 withholding statements and/or 1099
- ☐ Copy of proof of pension amount
- ☐ Approval/Denial forms of pub aid, unempl., WC
- ☐ 401k/Retirement account balance
- ☐ Regular savings and/or checking acct balance

**STATED/CONFIRMED MONTHLY INCOME:** ☐ **STATED/CONFIRMED RESERVES VALUE:** ☐

**Please provide the details of current or expected financial concerns:**

_____

_____

**Based on family <u>income</u> and applicable family or household size, please circle current number of members living in the household.**

| | TOTAL PERSONS IN FAMILY OR HOUSEHOLD | | | | |
|---|---|---|---|---|---|
| **Monthly Income** | 1 | 2 | 3 | 4 | **DISCOUNT** |
| Less than / equal to | $1,944 | $2,620 | $3,298 | $3,974 | **100%** |
| **Monthly Income** | 5 | 6 | 7 | 8 or > | **DISCOUNT** |
| Less than / equal to | $4,650 | $5,328 | $6,004 | $6,680 | **100%** |

**Please indicate total family <u>reserves</u> (Life insurance value, 401k, Retirement accounts, savings, other investments)**

| | TOTAL PERSONS IN FAMILY OR HOUSEHOLD | | | | |
|---|---|---|---|---|---|
| **Total Reserves** | 1 | 2 | 3 | 4 | **DISCOUNT** |
| Less than / equal to | $50,000 | $67,500 | $91,125 | $123,019 | **100%** |
| **Total Reserves** | 5 | 6 | 7 | 8 or > | **DISCOUNT** |
| Less than / equal to | $166,075 | $224,202 | $302,672 | $408,608 | **100%** |

**PATIENT ATTESTATION: This is to advise that I have pursued all other avenues possible, including private insurance, governmental and charitable agencies providing funding and relief from financial obligations as well as public aid. Therefore, I hereby request that BrightSpring Hospice Foundation make a determination of my eligibility for (Home Health / Hospice / Hospital) services on a reduced fee basis. I understand that the information, which I submit concerning my annual income, family size and asset reserves, is subject to verification.**

Name: _____ DOB: _____ SSN: _____
(Patient)

Name: _____ DOB: _____ SSN: _____
(Guarantor / Responsible Party)

Street Address: _____
(Guarantor) City State Zip

Telephone: _____ Marital Status: _____ # of Dependents: _____ Ages: _____