MONROE COUNTY
HOSPITAL
NAVICENT HEALTH PARTNER

INDIGENT CARE APPLICATION

Patient Name:_____ DOB:_____ Phone:_____

Address:_____SSN:_____

City:_____ State:_____ Zip Code:_____

Person Responsible for Bill:_____

_____

List all persons in the household. Start with the patient: Include SSN=Social Security Number, DOB=Date of Birth, and REL=Relationship to the Patient.

Last Name, First Name	SSN	Marital Status	REL	DOB	Employer	Income

Medicare#:_____ Ins Co:_____ Policy#:_____

Medicaid#:_____ Veteran Benefits: □ Yes □ No

I will make application for any service(s) (Medicare, Medicaid, Insurance, Etc) which may be available for payment of my bill. I will take any action reasonably required to obtain help. I will assign, or pay Monroe County Hospital the amount received from such a source for the hospital bill. I hereby authorize Monroe County Hospital to investigate and obtain information necessary
to determine eligibility for services. Any person who knowingly and with intent to defraud any insurance company or other person containing any materially false information, or conceals any information concerning any false material hereto, commits a fraudulent insurance act, which is a crime.

Applicant Signature: _____Date:_____

Counselor Signature: _____Date:_____

Manager Approval: _____Date:_____

Resources	Amount	Resources	Amount	Location
Child Support		Checking Account		
Unemployment		Savings Account		
Alimony		Cash		
Ret/Pension		Trust Fund		
Food Stamps		Stocks/Bonds		
Other		Other		

Assets	Description	Value	Balance	Payment	Creditor
House Note					
Real Estate					
Auto No1					
Auto No 2					
Other					

Internal Use Only:

Number of Dependents:_____ Total accountable Income: $_____

Verification of Income Supplied: ☐ Yes ☐ No

Eligible for IC (free) services: ☐ Yes ☐ No Eligible for discount:_____%

Ineligible: ☐ Reason: _____

Notice Mailed:_____ Counselor Initials: _____Date:_____

Account	Date of Service	Amount	Type of Service