**PRATT HEALTHCARE**

REQUIRED INFORMATION FOR CONSIDERATION OF CHARITY PROGRAM DISCOUNT

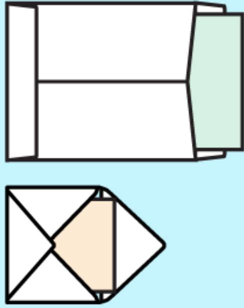
In order to process your application, proof of income is required. If your request is for services prior to the current year, proof of income for that specific year is required. A list of acceptable documentation is listed below. A signature and identification card must be submitted along with your completed application in order to process.

- VALID DRIVERS LICENSE OR IDENTIFICATION CARD
- MOST RECENT IRS TAX FORMS (1040 AND/OR W-2) MUST BE SIGNED
- CHECK STUBS FOR THE PAST 30 DAYS FOR ALL QUALIFYING PERSONS EMPLOYED IN THE HOME
- PROOF OF ALL OTHER INCOME RECEIVED IN THE PAST 30 DAYS
- MOST RECENT BANK STATEMENT
- AWARD OR DENIAL LETTER FROM SOCIAL SECURITY/DISABILITY
- UNEMPLOYMENT LETTER/CHECK STUBS FOR THE PAST 30 DAYS
- MEDICAID CARD IF APPLICABLE

***We will be unable to process your request without your signature. A picture identification card, proof of income or if application is incomplete.***

Should you have any questions about the application or required documents, please call our customer service department at (540) 786-2100.

Please return all items (as applicable) on this list, along with your completed application, to the address listed.



Please fill out application and return the application and all requested information to:

Pratt Healthcare
Attn: Charity Dept.
PO Box 1460
Fredericksburg, VA 22402-1460

# Charity Program Application

# Pratt Healthcare

Charity Application
Eligibility Determination

Patient Name: ______________________________

Patient Address: ______________________________

Phone # ____________________ Cell # ____________________

Account(s) # ____________________ **Current Balance**: $ ______________

Application Requested by: ____________________ Relation to Patient: ______________

*List every member of the patient's household, including patient, **as listed on the tax return**.*

| Name | Age | Relation | Gross Monthly In- | Employer |
|---|---|---|---|---|
| | | Self | | |
| | | Spouse | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Total # of People in Household: ________ Do you own ______ or rent _______your home:?

**All Other Sources of Income** **Gross Income Amount per Month**

(Public Assistance, Unemployment, Work Comp, Child Support, etc.)

______________________________ ____________________

______________________________ ____________________

______________________________ ____________________

**Check Any of the Following Medical Insurances that you have:**

_______ Commercial _ ________ Veteran's __________ Champus/Tricare ________ Medicare

_______ Medicaid __________ State & Local __________ Public Health

Were these services due to an accident in which you may have a claim or be represented by an attorney? ______

If yes, what is the attorney's name and phone number?

______________________________

*I certify that the above information is true and correct. I authorize Pratt Medical Center to verify this information with employers and other agencies. I also understand that this information is subject to review by Federal and/or State agencies. I also understand that I am expected to make application to any other assistance which may be available to me.*

Signature: ______________________________ Date Requested ______________

TO BE COMPLETED BY OFFICE

Date Received: ______________ By:__________ Documents for income Verification Attached?__________

Documents Needed: ______________________________

Approved ☐ Denied ☐ Reason:

______________________________

Date Charity Begins: ______________________ Approved by: ______________________