Charity Care Policy

I. POLICY:

The determination of Charity Care generally should be made at the time of admission, or shortly thereafter. However, events after discharge could change the ability of the patient to pay. Designation as Charity Care will only be considered after all payment sources have been exhausted. The co-pay amount will be pursued for all charity accounts with the exception of deceased and homeless patients with no other guarantor. Patient account transactions for Charity Care must be posted in the month the determination is made.

The flat rate "co-pay" amount is based on patient type. Emergency patients and outpatients are required to pay $100 flat rate and inpatients are required to pay $200 per day, with a $2,000 cap.

In the event the account has been assigned as Bad Debt to SOS/CFC as part of the monthly SOS journal entry, it will reverse the PA recovery that was given on an account determined to be Charity Care.

Note: EMPLOYEES OF TENET SHOULD NOT, AT ANY TIME, INDICATE OR SUGGEST TO THE PATIENT THAT HE/SHE WILL BE RELIEVED OF THE DEBT BY WAY OF A WRITE-OFF TO CHARITY CARE UNTIL THE DETERMINATION HAS BEEN MADE.

II. SCOPE:

All Tenet Patient Accounting Platforms

III. PURPOSE:

To define Charity Care and to distinguish Charity Care from accounts assigned to Bad Debt. Additionally, to establish policies and procedures to ensure consistent identification, accountability, and recording of charity at all Tenet entities and facilities.

IV. DEFINITIONS:

Charity Care represents all healthcare services that are provided to patients who are financially unable to satisfy their debts, resulting from a determination of a patient's inability to pay, not their willingness to pay. Hospital charges for patient accounts identified as Charity Care at the time of admission or service are not recognized by the facility as net revenue or net receivables. If patient accounts are identified as Charity Care subsequent to the facility recognizing the charges as revenue, an adjustment is required to appropriately classify the revenue and any Bad Debt expense previously recorded.

Charity Care will be classified into four categories:

A. Charity Care – Statutory

Statutory Charity Care will be defined by facility participation in various Federal, State, and/or County uncompensated care programs. Criteria for such Charity Care must comply with governmental guidelines and/or State or County regulations. Statutory Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility. Each patient who appears eligible for Statutory Charity Care determination and requests such determination must complete a Confidential Medical and Financial Assistance Application (hereafter referred to as the Confidential Financial Application—or, as application—as illustrated in *Exhibit B*). The patient/guarantor must complete all areas of the application and attest to the accuracy of the information by signing the application. The application will be processed in accordance with the Tenet Charity Care Program Policy and Procedures.

Each facility may need to have a number of Statutory Charity Care accounts to provide for the separation and identification of Charity Care by specific program and/or obligation. Statutory Charity Care will generally be identified at the time of admission by the facility, Tenet Financial Assistance Center (TFAC), or while the patient is in-house; however, it may also be identified after discharge.

The following accounts have been added to the Acute Chart of Accounts:

1. 5950-3934 Charity Discount - Statutory I/P
2. 5950-4934 Charity Discount - Statutory E/R
3. 5950-6934 Charity Discount - Statutory O/P

B. Charity Care – Non-Statutory

Non-Statutory Charity Care is defined as patient Charity Care meeting Tenet's Charity Care criteria; however, there may not be State or County programs in which the facility participates or where the facility does not have specific obligations to provide Charity Care. TFAC will determine eligibility for Non-Statutory Charity Care. The determination will be performed after the Confidential Financial Application is submitted for processing. An effort will be made to secure a signed application, but this may not be possible in all cases and will not prevent an account from being qualified by TFAC as Charity Care.

The following account descriptions have been revised in the Acute Chart of Accounts:

1. 5950-3935 Charity Discount - Non-Statutory I/P
2. 5950-4935 Charity Discount - Non-Statutory E/R
3. 5950-6935 Charity Discount - Non-Statutory O/P

C. Charity Care – Medicaid Denied Stays/Care, Non-Covered Services

Medicaid Charity Care will be defined as a category of patients who qualify for Medicaid, pursuant to governmental guidelines and/or State or County regulations, but where an outstanding patient balance exists, excluding waivers of deductibles and co-payments, unless otherwise documented and compliant with Tenet Regulatory Compliance Policy guidelines. Medicaid Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility.

Each patient who appears to be eligible for Medicaid Charity Care determination will not be required to complete a Confidential Financial Application due to the fact that Medicaid eligibility, in itself, is deemed to meet the requirements of Charity and, therefore, meets Tenet's criteria for Charity Care.

Under the Tenet Medicaid Charity Care Policy definition, these patients are eligible for Charity Care write-offs. Charges not billable or "un-billable" to the patient may not be claimed as Charity Care where it is not allowed by State law/regulation. Billable charges related to denied days, denied days of care, non-covered services, and any denied treatment authorizations will be included as Medicaid Charity Care. In addition, Medicare patients who have Medicaid coverage for their co insurance deductibles for which Medicaid will not make any additional payment, and for which Medicare does not ultimately provide Bad Debt reimbursement, will also be included as Charity Care.

At no time shall a facility claim Charity Care attributed to Medicaid billable charges as either Statutory or Non-Statutory Charity.

The following account descriptions have been revised in the Acute Chart of Accounts:

1. 5950-3940 Medicaid Denied Days I/P
2. 5950-4940 Medicaid Denied Services E/R
3. 5950-6940 Medicaid Denied Services O/P

D. Charity Care – Catastrophic Medically Indigent

For patients whose family income to the Federal Poverty Guidelines (FPG) ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for the Catastrophic Medically Indigent category. The determination for this is completed after comparing the patient's gross income, income to FPG ratio, and amount of hospital charges as follows:

1. **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.

2. **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $24,680 x 2 = $49,360).

3. **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.

4. **Unable to Pay**—It is determined the patient is unable to pay.

The following account descriptions have been revised in the Acute Chart of Accounts:

1. 5950-3941 Catastrophic Medically Indigent Discount - I/P

2. 5950-4941 Catastrophic Medically Indigent Discount - E/R

3. 5950-6941 Catastrophic Medically Indigent Discount - O/P

V. PROCEDURE:

The hospital Financial Counselor or MEP Patient Advocate will attempt to identify potential Statutory and Non-Statutory Charity Care at the time of admission or while the patient is in-house. At the time of Charity identification, the financial class will be changed to Charity Care, the co-pay will be collected based on admission type, and a 100% Charity Care allowance should be taken for these patients. At the time of the financial class change, the patient's account will be assigned to TFAC and the Confidential Financial Application should be forwarded to TFAC for review and processing. Additionally, all CFC-, MEP-, and Early Out-assigned patient accounts—post-discharge—that qualify to be reviewed for Charity Care should be forwarded to TFAC. Completed Charity Care packets will be forwarded to the respective facility. TFAC will also retain the Charity Care packets, including applications for Charity Care, appropriate back-up documentation, and recommendations for possible retrospective audit by the Business Office and/or Tenet Audit Services.

A. Factors to be Considered

Factors to be considered in determining eligibility for Charity Care must include comparing the patient's gross income to the annually published FPG, or an equivalent thereof. The patient's gross income information may be obtained from a Confidential Financial Application, but is not required. This information may be obtained through verbal means from the patient/guarantor and documented by a MEP Patient Advocate, Financial Counselor, Financial Assistance Coordinator, or other specifically designated Tenet employee.

Other factors may include, but are not limited to, the following:

1. The patient's employment status, credit status, and capacity for future earnings.
    a) Patients who are unemployed and do not qualify for a government program
    b) Patients who have no credit established and no Bad Debt collection accounts
    c) Patients with a lack of revolving credit account(s) information
    d) Patients with a lack of revolving bank accounts(s) information
    e) Patients with delinquencies reported on open trade line accounts
2. The previous exhaustion of all other available resources.
3. International patients are considered on a case-by-case basis for ER treatment and/or ER admission only.
4. Catastrophic illness.

VI. MEP PROCEDURE:

The MEP Patient Advocate should screen patients for potential linkage to Government/County programs. During the screening process, the Advocate should secure a Confidential Financial Application. The application is to be used for potential Charity Care determination only in the event MEP is unable to obtain eligibility for the patient for Government Programs reimbursement. For potential linkage to Government/County programs, the Patient Advocate will:

A. Change the financial class and assign the account to MEP within five days from date of discharge, thereby, netting the account to expected governmental reimbursement.

B. Make a final determination as to whether linkage will prevail within an additional 25 days from the assignment date, totaling no more than 30 days from date of discharge.

C. Return the account to the facility for assignment by the Business Office to Early Out for Self-Pay if it is determined that program linkage will not prevail within the additional 25 days from assignment date, and there are no other payment or third-party payment sources. Those meeting the financial guidelines for Charity Care will be assigned by the Business Office to TFAC with the appropriate financial class. The co-pay should be collected by the hospital's Financial Counselor, Business Office representative, or TFAC representative.

If, during the initial interview with the patient, it is revealed that there is no viable source of payment and the patient will not qualify for any governmental programs, the Patient Advocate will:

A. Offer the patient a Confidential Financial Application form.

B. Assist the patient in completing a Confidential Financial Application, which will document the patient's financial need.

C. Obtain the patient's signature on the Confidential Financial Application and forward the application to the Financial Counselor or TFAC, as deemed appropriate.

D. Refer the patient to the hospital Financial Counselor for collection of the co-pay.

MEP Processing for Charity Care

For those accounts that remain in MEP past 30 days from assignment with no government program linkage and that meet the financial criteria for Charity Care, MEP should have gathered all substantial information to enable the facility to affect Tenet's Charity Care Policy. Included in the Charity Care packet is a Confidential Financial Application. If the MEP representative has exhausted all efforts to secure all necessary verifications, the application for Charity Care should be submitted to TFAC for review and finalization without the verifications.

MEP is required to notify the Business Office of the inability to obtain eligibility, or the potential qualification for Charity Care classification, and to return the account to the Business Office.

The Business Office is required to update the plan ID and financial class for assignment to TFAC.

TFAC will further assess the application.

VII. FINANCIAL COUNSELOR PROCEDURE:

Patients assessed by a Financial Counselor to have no third-party coverage and/or benefits available will:

A. Be offered the facility flat rate or Prompt Pay Discount Program where allowed by State law/regulation.

B. Be assessed for Charity Care in the event he or she is unable to pay the facility flat rate or Prompt Pay Discount Program amount (as applicable to State law/regulation), and meets the income/asset and other guidelines set forth by the Charity Care Policy.

The Financial Counselor will take the appropriate steps as outlined below:

A. For patients who appear to meet the income guidelines set forth in this policy for Charity Care, the account should be updated with the financial class of Charity on the facility system, at which time, a 100% Charity Care reserve should be taken and the co-pay amount should be collected. The patient account is then assigned to TFAC for review follow-up and a final Charity Care recommendation. The Financial Counselor should forward the Confidential Financial Application to TFAC.

B. Patients who do not qualify for Charity Care should be treated as a Self-Pay, and standard A/R collection procedures will apply.

VIII. TENET FINANCIAL ASSISTANCE CENTER:

All accounts assigned to TFAC that are potentially Charity Care will be evaluated within 25 days. During the assessment period, the account's financial class may be changed to Charity Care on the facility's system and a 100% reserve taken.

Those accounts that do not meet the financial guidelines, which were assigned to TFAC for Charity Care assessment, will have the financial class changed to Self-Pay on the facility's system and will be assigned to Early Out.

For patient accounts meeting the Charity Care guidelines:

A. The TFAC Financial Assessment Coordinator will gather all substantial information to enable the facility to affect Tenet's Charity Care Policy.

B. The Charity Care packet should include a Confidential Financial Application, a Credit Bureau Report, and any other documents that substantiate the patient's financial need for Charity consideration. Where the patient is unable to complete a written Confidential Financial Application, verbal attestation is acceptable.

The amount of information to support a Charity Care recommendation will vary depending on TFAC's ability to effectively obtain the information from the patient or family.

When TFAC is unable to obtain hard-copy documentation from the patient or family, but all indications—from the information received verbally or in writing at the time of service (or soon thereafter)—are that the patient would qualify for Charity Care, then TFAC will complete a Confidential Financial Application recommending Charity Care. The application will include:

1. A Credit Bureau Report or summary
2. An analysis that supports the recommendation for a Charity Care adjustment

C. The Financial Assessment Coordinator will attempt to secure supporting documentation. Income and/or assets may be verified by attaching any one or more of the following:

1. Credit Bureau Report (including the lack thereof)
2. IRS tax returns
3. Payroll stubs
4. Declarations
5. Verbal attestation
6. Other forms used to substantiate the need for Charity Care consideration

D. The Financial Assessment Coordinator will apply FPG guidelines by using the FPG table (refer to *Exhibit A*), which is updated annually. The patient's family size is used to determine whether monthly or annual income falls at, below, or exceeds 200% of the FPG. Where State law/regulation does not allow for consideration of Charity up to 200% of the FPG, the State law/regulation will take precedent and be enforced.

1. If the family gross income falls below, or is at the designated income of the FPG ratio threshold, the patient's account will be considered for Charity Care adjustment at 100% minus the co-pay amount

   Note: Tenet Policy's ratio is 200%, which is influenced by State law/regulation.

2. For patients whose family income to the FPG ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for a Catastrophic Medically Indigent discount. The calculation for this is completed after comparing the patient's gross income, income to the FPG ratio, and the amount of hospital charges as follows:

   a) **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.

   b) **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $24,680 x 2 = $49,360).

   c) **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.

   d) **Unable to Pay**—It is determined the patient is unable to pay.

      Note: All four of the above criteria must be met for consideration as Catastrophic Medically Indigent.

3. If the co-pay was not collected at the time of service, the Financial Assistance Coordinator will attempt to collect the amount before the Charity Care packet is submitted.

E. The Financial Assistance Coordinator will complete a Confidential Financial Application that indicates there are no other payment sources and the patient meets the income of the FPG guidelines.

F. TFAC is to review the application for Charity Care for appropriateness and completeness. Initialing the application indicates that it has been reviewed and meets the requirements for submission to the facility for Charity Care consideration and administrative adjustment.

G. If the TFAC representative has exhausted all efforts for those patients who meet Government Programs or Charity Care criteria, but are unable to complete the required applications and documentation (e.g., unable to contact the patient, unable to provide sufficient documentation, etc.), and/or have a potential change in future circumstances and recovery, then the account will not be recommended for a Charity Care allowance.

H. Those patients who do not meet the guidelines for Charity Care will have their accounts changed back to Self-Pay, and standard A/R follow-up will begin.

At all times, the Collection, Support, and Management staff of TFAC are required to input complete documentation on the account of all actions taken and all information received from the patient. It is the responsibility of the TFAC Operations management to ensure adherence to this policy.

IX. DOCUMENTATION:

A. Confidential Financial Application

In order to qualify for Charity Care, Tenet requests each patient or family to complete the Confidential Financial Application. This application allows the collection of information about income and the documentation of other requirements as defined below. Pending the completion of the application, the patient should be treated as a Charity Care patient in accordance with Tenet's Charity Care Policy as set forth here. The patient's account will have the financial class changed to Charity Care on the facility's HIS system.

In cases where the patient is unable to complete the written application, verbal attestation is acceptable if it is not disallowed by State law/regulation.

A Confidential Financial Application completed by the patient may not be required for patients who are deemed to be already eligible for other Federal, State, and County Assistance Programs. Such programs include, but are not limited to Medicaid, County Assistance Programs, MIA, MSI, AFDC, Food Stamps, and WIC.

1. **Family Members**—Tenet will require patients to provide the number of family members in their household.

   a) Adults—To calculate the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all of their dependents.

b) Minors—To calculate the number of family members in a minor patient's household, include the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

2. **Income Calculation**—Tenet requires patients to provide their household's yearly gross income.

   a) Adults—The term "yearly income" on the application means the sum of the total yearly gross income of the patient and the patient's spouse.

   b) Minors—If the patient is a minor, the term "yearly income" means the income from the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

3. **Expired Patients**—Expired patients may be deemed to have no income for purposes of the Tenet calculation of income. Although no documentation of income and no Confidential Financial Application are required for expired patients, the patient's financial status will be reviewed at the time of death by TFAC to ensure that a Charity Care adjustment is appropriate. The co-pay will be waived if no other guarantor appears on the patient account.

4. **Homeless Patients**—Patients may be deemed homeless once verification processes have been exhausted by TFAC. The co-pay will be waived if no other guarantor appears on the patient account.

B. Income Verification

Tenet requests patients to attest to the income set forth in the application. In determining a patient's total income, Tenet may consider other financial assets and liabilities of the patient, as well as, the patient's family income, when assessing the ability to pay. If a determination is made that the patient has the ability to pay their bill, such determination does not preclude a reassessment of the patient's ability to pay upon presentation of additional documentation. Any of the following documents are appropriate for substantiating the need for Charity Care:

1. **Income Documentation**—Income documentation may include IRS W-2 form, Wage and Earnings Statement, paycheck stub, tax returns, telephone verification by employer of the patient's income, signed attestation to income, bank statements, or verbal verification from patient.

2. **Participation in a Public Benefit Program**—Public Benefit Program documentation showing current participation in programs, such as Social Security, Workers' Compensation, Unemployment Insurance, Medicaid, County Assistance Programs, AFDC, Food Stamps, WIC, or other similar indigence-related programs.

3. **Assets**—All liquid assets should be considered as a possible source of payment for services rendered. For patients with no source of regular income (employment, SSI, disability, etc.) other than liquid assets, those assets would be the patient's income source and should be measured against the FPG.

C. Information Falsification

Information falsification will result in denial of the Charity Care application. If, after a patient is granted financial assistance, the hospital/SOS finds material provision(s) of the application to be untrue, Charity Care status may be revoked and the patient's account will follow the normal collection processes.

D. Revenue Classification

It will be the responsibility of each Business Office to maintain the integrity of account classification on the hospital patient accounting system. Prior to month-end close, TFAC is responsible for providing detailed reports listing critical changes in account class between Self-Pay and Charity for any A/R account assigned to TFAC. The Business Office is required to use those reports to update the changes in the patient accounting system prior to the month-end.

Critical changes in account class are defined as:

1. Any account originally assigned to TFAC as Self-Pay that is re-classed as a result of meeting the criteria for Charity Care

2. Any account originally assigned to TFAC as Charity that is re-classed to Self-Pay as a result of denying Charity Care

E. Denied Charity Care Recommendations

In the event the CFO denies a patient's application for Charity Care, documentation is to be placed in the facility collection system as to the reason for the rejection of the recommendation. The CFO is also to indicate on the Confidential Financial Application the reason for denial and the date of the denial. The packet is then to be forwarded to TFAC for review. After an initial review and discussion with the CFO, for those patient accounts where disagreement still prevails, and the accounts that meet Tenet guidelines for Charity Care as set forth here, a denial summary will be sent to the respective Tenet Regional Vice President of Finance by TFAC for resolution. For those patient accounts that the Regional Vice President of Finance has denied that have met the Tenet Charity Care guidelines as set forth here, a denial summary will be sent to the respective Tenet Divisional Senior Vice President of Finance for conference and resolution.

F. Custodian of Records

TFAC will serve as the custodian of records for all Charity Care documentation for all accounts identified by SOS, MEP, and CPFS.

G. Reservation of Rights

It is the policy of Tenet and the hospital to reserve the right to limit or deny financial assistance at their sole discretion.

1. **Non-Covered Services**—It is the policy of Tenet and the hospital to reserve the right to designate certain services that are not subject to the hospital's Charity Care Policy.

2. **No Effect on Other Tenet Regions/Hospital Policies**—This policy shall not alter or modify other Tenet policies regarding efforts to obtain payments from third-party payers, patient transfers, emergency care, State-specific regulations, State-specific requirements for Statutory Charity Care classification, or programs for uncompensated care.

X. EXHIBIT A – FEDERAL POVERTY GUIDELINES:

2004 Federal Poverty Guidelines (FPG) are as follows:

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$9,310	18,620	27,930	$11,630	23,260	34,890	$10,700	21,400	32,100
2	12,490	24,980	37,470	15,610	31,220	46,830	14,360	28,720	43,080
3	15,670	31,340	47,010	19,590	39,180	58,770	18,020	36,040	54,060
4	18,850	37,700	56,550	23,570	47,140	70,710	21,680	43,360	65,040
5	22,030	44,060	66,090	27,550	55,100	82,650	25,340	50,680	76,020
6	25,210	50,420	75,630	31,530	63,060	94,590	29,000	58,000	87,000
7	28,390	56,780	85,170	35,510	71,020	106,530	32,660	65,320	97,980
8	31,570	63,140	94,710	39,490	78,980	118,470	36,320	72,640	108,960
Each additional person, add	3,180	6,360	9,540	3,980	7,960	11,940	3,660	7,320	10,980

XI. EXHIBIT B – CONFIDENTIAL FINANCIAL APPLICATION:

Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name	SSN	DOB
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

SECTION A

MEDICAL ASSISTANCE SCREENING – *Please circle answer "Y" for yes or "N" for no.*

1.	Is the patient under age 21 or over age 65?	Y / N	5.	Is the patient pregnant, or was the admission pregnancy-related?	Y / N
2.	Is the patient a single parent of a child under age 21?	Y / N	6.	Will the patient potentially be disabled for 12 months?	Y / N
3.	Is the patient a caretaker or guardian of a child under 21?	Y / N	7.	Is the patient a Victim of Crime?	Y / N
4.	Is the patient a married parent of a minor child? *If yes, does the patient have a 30-day incapacitation?*	Y / N	8.	Does the patient have a "COBRA" or insurance policy that the premium has lapsed?	Y / N

SECTION B

FINANCIAL ASSISTANCE SCREENING

Total Number of Dependent Family Members in Household _____

(Include patient, patient's spouse and/or legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $_____ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size

_____ ÷ _____ = _____%

Type of Service Circle one ER OP IP

Service Date _____ to _____

Co-Pay Amount $_____

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$9,310	18,620	27,930	$11,630	23,260	34,890	$10,700	21,400	32,100
2	12,490	24,980	37,470	15,610	31,220	46,830	14,360	28,720	43,080
3	15,670	31,340	47,010	19,590	39,180	58,770	18,020	36,040	54,060
4	18,850	37,700	56,550	23,570	47,140	70,710	21,680	43,360	65,040
5	22,030	44,060	66,090	27,550	55,100	82,650	25,340	50,680	76,020
6	25,210	50,420	75,630	31,530	63,060	94,590	29,000	58,000	87,000
7	28,390	56,780	85,170	35,510	71,020	106,530	32,660	65,320	97,980
8	31,570	63,140	94,710	39,490	78,980	118,470	36,320	72,640	108,960
Each additional person, add	3,180	6,360	9,540	3,980	7,960	11,940	3,660	7,320	10,980

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Check One - Hourly Daily Weekly Monthly Yearly	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	Check One - Living on Savings/Annuity Live with parent/family/friends Homeless Shelter	

SPOUSE

Responsibility Party:		
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Check One - Hourly Daily Weekly Monthly Yearly	
	Hours Per Week:	

HOMELESS AFFIDAVIT

I, _____, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others.
Patient/Guarantor Initials _____

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor, and in accordance with statue, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Tenet Charity Care programs is a "Payer of Last Resort" and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which Tenet's or its subsidiaries provided care.

_____ _____

PATIENT/GUARANTOR SIGNATURE **DATE**

OFFICE USE ONLY

Family Size:	Account Number(s)	Balance	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			
Recommendation:			
_____		_____	_____
Prepared by		Date	Unit
_____		_____	_____
Approved or Denied by		Date	Title