# PROWERS MEDICAL CENTER CHARITY APPLICATION

**APPLICANT INFORMATION:**

**DATE: _____**

| **Last Name:** | **First Name:** | **M.I.** | **Phone:**<br>**Home ( )**<br>**Cell ( )** |
|---|---|---|---|
| **Address:** | **City/Zip Code:** | | |

| List Household Members | Relationship Code | Date of Birth | Social Security Number / or ID# |
|---|---|---|---|
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**Relation Codes: 1 Self 2 Spouse 3 Child 4 Stepchild 5 Other**

**Notes:**

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## FINANCES:

| CREDITOR | MONTHLY PAYMENT | ADDITIONAL INFORMATION | CREDITOR | MONTHLY PAYMENT | ADDITIONAL INFORMATION |
|---|---|---|---|---|---|
| Elder Care | | | Health Insurance Premiums | | |
| Day Care | | | Pharmaceuticals | | |
| Paid Alimony | | | Medical Expenses | | |
| Child Support | | | | | |

## INCOME:

| INCOME SOURCE | MONTHLY AMOUNT | ANNUALIZED TOTAL | EQUITY IN RESOURCES | ACTUAL VALUE | MINUS AMT OWED | EQUALS EQUITY | MINUS PROTECTED | EQUITY CALCULATION |
|---|---|---|---|---|---|---|---|---|
| 1. Net Employment Income | | | 7. Vehicle Equity<br>Make/Model | | | | $4500.00 | |
| 2. Self Employment Income | | | 8. Real Property | | | | | |
| 3. Unearned Income | | | 9. Liquid Resources | | | | | |
| 4. Total Income (1+2+3) | | | 10. Business Equity | | | | | |
| 5. Monthly Expense or In Kind Income | | | **11. Total Equity** (7+8+9+10) | | | | | |
| | | | 12. Less Family Size Deduction | Family Size | | | X $2500.00 | |
| | | | 13. Equity Resources Calculation<br>(11 minus 12; cannot be a negative number) | | | | | |
| | | | 14. Total Family Financial Status | | | | | |
| | | | 15. Minus Allowable Deductions | | | | | |
| | | | 16. **Equals Income and Equity (14 - 15)** | | | | | |

Additional Comments:

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_____
_____
_____
_____

Charity Care Percentage Deduction: _____

_____ _____
Print or Type Applicant Name Applicant Signature and Date

_____ _____
Print or Type Patient Financial Representative Name Patient Financial Representative Signature

**PROWERS MEDICAL CENTER**
**719-336-4343**