ADVENTIST HEALTHCARE
NOTICE OF AVAILIBILITY OF CHARITY CARE

Shady Grove Adventist, Adventist Behavioral Health, Washington Adventist Hospital and Adventist Rehab Hospital of Maryland will make available a reasonable amount of health care without charge to persons eligible under Community Services Administration guidelines. Charity Care is available to patients whose family income does not exceed the limits designated by the Income Poverty Guidelines established by the Community Services Administration. The current income requirements are the following. If your income is not more than five time these amounts, you may qualify for Charity Care.

Size of Family Unit	**Guideline**
1	$11,490
2	$15,510
3	$19,530
4	$23,550
5	$27,570
6	$31,590
7	$35,590
8	$39,630

Note: The guidelines increase **$4,020** for each additional family member.

If you feel you may be eligible for Charity Care and wish to apply, please obtain an application for Community Charity Care from the Admissions Office or by calling (301) 315-3660. A written determination of your eligibility will be made two business days of the receipt of your completed application.

Revised July 2013

ADVENTIST HEALTHCARE

Patient Financial Services, 820 W. Diamond Ave Ste 500, Gaithersburg, MD 20878

☐ Washington Adventist Hospital ☐ Adventist Behavioral Hospital
☐ Shady Grove Adventist Hospital ☐ Adventist Rehabilitation Hospital of Maryland

CHARITY CARE APPLICATION- DEMOGRAPHICS

Date: _____Account Number(s)_____

Patient Name: _____ Birth Date: _____

Address: _____ Sex: _____

Home Telephone: _____ Work Telephone: _____ Cell Phone: _____

Social Security #: _____ US Citizen: _____ No Residence: _____

Marital Status: ___ Married ___ Single ___ Divorced

Name of Person Completing Application_____

Dependents Listed on Tax Form:

Name: _____ Age: ____Relationship:_____
Name: _____ Age: ____Relationship: _____
Name: _____ Age: ____Relationship: _____
Name: _____ Age: ____Relationship: _____

Employment: Patient employer	**Spouse employer**
Name: _____	Name:_____
Address: _____	Address: _____
Telephone #: _____	Telephone #:_____
Social Security #: _____	Social Security #: _____
How long employed: _____	How long employed: _____

TOTAL FAMILY INCOME $_____

Note: All Financial applications must be accompanied by income verification for each working family member. Be sure you have attached income verification for all amounts listed above. This verification may be in the following forms: minimum of 3 months worth of pay-stubs, an official income verification letter from your employer and/or your current taxes or W-2s. If you are not working and are not receiving state or county assistance, please include a "Letter of Support" from the individual or organization that is covering your living expenses. Any missing documents will result in a delay in processing your application or could cause your application to be denied. Thank you for your cooperation

CHARITY CARE APPLICATION- LIVING EXPENSES

EXPENSES:

Rent / Mortgage _____
Food _____
Transportation _____
Utilities _____
Health Insurance premiums _____
Medical expenses not covered by insurance _____

Doctor: _____
_____
_____

Hospital: _____
_____

TOTAL: _____

Has the applicant ever applied or is currently applying for Medical Assistance?

Please Circle the appropriate answer: **YES or NO**

If yes, please provide the status of your application below (caseworker name, DSS office location, etc.)

I hereby certify that to the best of my knowledge and belief, the information listed on this statement is true and represents a complete statement of my family size and income for the time period indicated.

Applicant Signature: _____ Date: _____

Return Application To: Adventist HealthCare

Patient Financial Services

820 W. Diamond Ave Suite 500

Gaithersburg, MD 20878

Attn: Customer Service Manager