Catholic Health Services, Inc. Charity Admission Income Worksheet

Facility: (circle one) SJN SARH VM SCRH VMW SCW SAN ST. JOSEPH ELDERLY HSG

Patient Name: _____ Legal resident ? ____ Yes ____ No
(please print)
Account Number:_____ Date of Birth:_____

Dates of Service: _____ to _____

Diagnosis:_____
_____

PAYOR STATUS:
Medicare: ____ Yes ____ No ____Part A only ____Part B only
Medicaid Eligible: ____Yes Case Number: _____ ____No
Commercial Insurance:_____ Limits: _____
Policy Number:_____ Telephone Number _____

Estimated Annual Cost:		Annual Income:
ALF/Nursing Home/Hospital R&B/Housing	$	
Therapy		$_____
Medications		
Other		
Total	$	

Estimated length of care required:_____

Family Support:
Marital Status: Married □ Single □ Widowed □
Children:_____

Name:_____
Address:_____
Ability to Contribute:_____
Attach financial documentation. □ IRS Form 1040 or 1040EZ
Family Responsibility: $_____ per ____Day ____Week ____Month Other _____

GUIDELINES 2024
If income is below 200% (shown below) of the Federal Poverty Income Guideline, individual is eligible for FULL write-off. If income is above 200% but below 400% (shown below) individual is eligible for Partial write-off.

#in Household	1	2	3	4	5	6	7	8
200% of FPG	$30,120	$40,880	$51,640	$62,400	$73,160	83,920	$94,680	$105,440
400% of FPG	$60,240	$81,760	$103,280	$124,800	$146,320	$167,840	$189,360	$210,880

_____ Date:_____
Prepared by

DETERMINATION: _____ ACCEPT _____ DECLINE

_____ _____ _____ _____
Facility Administrator Date Accepted for processing by V.P of Revenue Management Date

_____ _____
CHS CEO and/or COO and/or CFO Date *[Rev. 1/2024]*