

# Hardin County General Hospital

## Indigent Care Application

Patient's Name \_\_\_\_\_ Account # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Date of Admission \_\_\_\_\_ Date of Discharge \_\_\_\_\_

Fill in the chart for yourself and other family members living with you.

Name	Date Of Birth	Relation	Currently Employed	Employer	Employed in the Past Year	Employer
			Yes or No		Yes or No	
			Yes or No		Yes or No	
			Yes or No		Yes or No	
			Yes or No		Yes or No	
			Yes or No		Yes or No	
			Yes or No		Yes or No	
			Yes or No		Yes or No	
			Yes or No		Yes or No	

I certify that to the best of my knowledge all of the information that I have provided is true and correct. I understand that if I have given false or misleading information, it could result in denial of my application and/or administrative finding resulting in the possibility of action against me by the facility. Also, I hereby authorize this hospital to disclose any of the above information to any State, Local, or Federal Agency responsible for this facility's Indigent Care Compliance.

\_\_\_\_\_  
Date of Request

\_\_\_\_\_  
Applicant's Signature

**NOTE: It is required that you provide proof of income for the past 12 months from the date of this application. This would include:**

- Income Tax Return**
- Most Recent Pay Stub (Everyone in Household)**
- Proof of Social Security/Disability**
- Most Recent Bank Statement**
- Most Recent Utility Bill**
- Proof of Food Stamps**
- Other \_\_\_\_\_**

**FOR HOSPITAL USE ONLY**

	12 Month Income	Family Size
Patient's Income		
Other Family Income		
Total Family Income		