APPLICATION FOR
FREE AND REDUCED-CHARGE SERVICES
UNDER THE ICTF PROGRAM
ARCHBOLD MEDICAL CENTER

Patient Name: _____ Date(s) of Service: _____
Amount of charges: $ _____
Name of applicant: _____ Relationship to patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____

List members of household, birth date, relationship to patient, and income from each source; state whether income is per week, month, or year:

Name	Birth Date	Relationship	Income (wk/mo/yr)	Total Income

If income of any member is from self-employment, you may give information on business costs so that we can determine actual income to be counted. Write details on the back of this sheet.

(Note to applicant: You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills, and would not have to be counted or report income.)

Signature of Applicant: _____ Date: _____

For Hospital Staff Use:

NUMBER COUNTED IN HOUSEHOLD: _____ TOTAL COUNTABLE INCOME: _____
(Average monthly income for last year or past 3 months, whichever is more favorable.)
Verification of income supplied (if requested)? Yes _____ No _____
Determination: Eligible for free services _____ Conditional? _____ Pending: _____
Eligible for discount: _____% Conditional? _____ Pending: _____
Ineligible: _____ Reason: _____
_____
Date notice mailed: _____ Staff Signature: _____ Date: _____
Reconsideration: _____ Result: _____ Date: _____