SAMUEL SIMMONDS
MEMORIAL HOSPITAL
COMMUNITY CARE APPLICATION

DATE SENT: _____
ACCT #: _____
RETURN TO: _____
DATE RECEIVED: _____
DATE REVIEWED: _____
REVIEWED BY: _____
APPROVED? YES/NO
FOR OFFICE USE ONLY

The information requested is to allow us determine if a financial hardship adjustment is warranted.
If you fail to complete the form correctly, or if you fail to provide the necessary/requested documentation, your request may be delayed or denied.

TO BE COMPLETED BY PERSON RESPONSIBLE FOR BILL

Medical Record Number _____

PATIENT

Name _____
Address _____
Home Phone _____
Employer _____
Occupation _____

SSN _____
Date of Birth _____
Work Phone _____

GUARANTOR (OR SPOUSE IF MARRIED)

Name _____
Address _____
Employer _____
Occupation _____
Relation _____

SSN _____
Date of Birth _____
Work Phone _____

FAMILY **# IN HOUSEHOLD** _____

Dependents _____ Age
_____ Age
_____ Age

Please mail completed application to:
Samuel Simmonds Memorial Hospital
Attn: Patient Accounts Dept
PO Box 29
Barrow, AK 99723

CHECKLIST ~ DID YOU???

- **Complete all the sections of the application?**
- **Sign and Date the application**
- **Attach copies of the your most recent Federal tax return**

Determinations of eligibility for Samuel Simmonds Community Care Program will be made in writing with 45 days from the date of return of completed application and will include instructions for reconsideration if applicable. If additional requested information is received the information will be reviewed and reconsidered. Please note: you will remain financially responsible for payments until such determination is made.

Community Care adjustments are for Medical Treatment only. If you are found to be eligible for the program, it will not cover any Pharmacy or Dental Charges

All information relating to this application will be kept confidential. Copies of the documents that support the application will be kept with the application form.

If you need assistance or have questions regarding this process, please call us at 907-852-9354 and we will be happy to assist you.

_____ _____

Signature of Patient/Guarantor Date