PRESUMPTIVE CHARITY APPLICATION CHECKLIST

You may qualify for financial assistance if you are currently enrolled in one of the specific assistance programs below. Please carefully review the list and indicate any you are enrolled in, and/or if one or more items correctly applies to you.

1.	State-funded prescription program	
2.	Homeless or received care from a homeless clinic	
3.	Participation in Women's, Infants and Children's program (WIC)	
4.	Food stamp eligibility	
5.	Subsidized school lunch program eligibility	
6.	Resides in low income/subsidized housing	
7.	Patient is deceased with no known estate	
8.	Patients with unpaid balances on three or more accounts	
9.	Insurance denials	
10.	Eligibility for other state or local assistance programs that are unfunded	
11.	Supplemental Nutrition Assistance Program (SNAP)	
12.	Medicaid	
13.	Children's Health Insurance Program (CHIP)	
14.	Temporary Assistance for Needy Families (TANF)	
15.	Unemployment insurance	
16.	Other similar third-party means tested programs	
17.	1-16 doesn't apply to the patient	

Application Certification: I certify that the information in the application is true and correct to the best of my knowledge. I understand that the information provided may be verified and I authorize Rice Medical Center / Rice Medical Associates to contact third parties if necessary to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital / clinic bill.

Account Number: _____ **Medical Record Number:** _____

Patient Name: _____ **Guarantor Name:** _____

Guarantor Signature: _____ **Date:** _____

CAHRMC, LLC Employee Signature: _____

☐ **Approved** ☐ **Denied** **Comments:** _____