HUH HOWARD UNIVERSITY HOSPITAL

HUH Financial Assistance Program Application

Application Information

Patient Last Name:	First Name:	Date of Birth:	Sex:	Salutation:

Street:	SSN/INTL ID No:	Country:

City:	State:	Zip:	Contact Phone:	Email Address:

Previous Application

Have you submitted an HUH Financial Assistance application before? ❒ No ❒ Yes;

If "Yes", what date was it submitted? _____ **OR** What was the "Account" number? _____

Encounter/Services Information

Admit Date:	Discharge Date:	❒ Outpatient ❒ Inpatient	Account:	Medical Record:	Billed Amount: $

Were you ever a patient at Howard University Hospital before this visit? ❒ No ❒ Yes

Was the treatment you received for injury or illness sustained because of any of the following?

❒ Motor Vehicle Accident Date: _____ What state did accident occur in? _____

❒ Assault Date: _____ What state did assault occur in? _____

❒ On the Job Injury/Illness Date: _____ What state did injury/illness occur in? _____

❒ Personal Injury Date: _____ What State did injury occur in? _____

Do you have an attorney representing you because of the above circumstances situation ❒ No ❒ Yes

(If you checked "Yes", please provide your attorney's information below.)

Attorney Name:	Phone:	eMail:

Street with Suite:	City:	State	Zip:

Employment Information

Status:

❒ Full Time ❒ Part Time: 1 Job ❒ Part Time: More than 1 Job ❒ Self Employed ❒ Retired

❒ Student ❒ Not Employed ❒ Not Employed with Unemployment Benefits ❒ Homemaker

Primary Employer Name:			Phone:
Street:	City:	State	Zip:
Additional Employer Name:			Phone:
Street:	City:	State	Zip:

Other Payor Information

Do you have Medicare of Medicaid Coverage? ❒ No ❒ Yes; If "Yes", please provide your identification number below.

❒ Medicaid #: _____ ❒ Medicare #: _____

Household Information

How many adults live in your household? _____ How many children live in your household? _____

(Continue on page 2.)

Household Information - *Continued from page 1.*

Name:	Age:	Relation:

Income & Expenses Information

Wages and Income *(Annual; Yearly)*		**Expenses & Debts** *(Monthly)*	
Wage – Self	$	Mortgage/Rent	$
Wage – Spouse	$	UTIL: Gas/Electric	$
Wage – Other Member	$	UTIL: Phone	$
Wage – Self Employ	$	UTIL: Mobile Phone	$
Social Security Benefit	$	UTIL: Food	$
Disability Benefit	$	Auto Insurance	$
Retirement/Pension Benefit	$	Credit Card(s)	$
Public Assistance Benefit	$	Health Insurance	$
Alimony	$	Other Medical Expenses	$
Child Support	$	Loan: Auto	$
Unemployment Benefit	$	Loan: School	$
Other:	$	Other:	$

Patient /Guarantor Acknowledgment

- I declare under penalty of perjury that the statements I have made and their supporting documents are an accurate reflection my inability to pay the amount due to Howard University Hospital.
- I understand that Howard University Hospital is required by law to keep the information I provide confidential.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse Howard University Hospital from any proceeds received from litigation or settlement resulting from such act.
- I understand that I will be billed for any balance remaining after any discount is applied to the noted account. If I am not able to pay this balance in full within 30 days of receipt of discounted bill. I will contact the HUH Financial Assistance Program office to make payment plan arrangements.

_____

Patient/Guarantor Signature & Date