MCHHS
MITCHELL COUNTY HOSPITAL
• HEALTH SYSTEMS •

APPLICATION FOR FINANCIAL ASSISTANCE

APPLICANT INFORMATION (PLEASE PRINT)			
Patient's Name:			
	First	Last	MI
Address:			
City:		State:	Zip Code:
Phone:		Work Phone:	
Age:	Male ☐ Female ☐	Marital Status:	Date of Birth:

APPLICANT EMPLOYMENT & INSURANCE INFORMATION (PLEASE PRINT)	
Employer:	
Health Insurance: Yes ☐ No ☐	Insurance Name:
Policy Holder Name:	
Policy Holder Relationship to Patient:	
Policy ID Number:	Group Number:
Claim Address/City/State/Zip	

SPOUSE/PARTNER INFORMATION (PLEASE PRINT)			
Name:			
	First	Last	MI
Address:			
City:		State:	Zip Code:
Phone:		Work Phone:	
Age:	Male ☐ Female ☐	Marital Status:	Date of Birth:

SPOUSE EMPLOYMENT & INSURANCE INFORMATION (PLEASE PRINT)	
Employer:	
Health Insurance: Yes ☐ No ☐	Insurance Name:
Policy Holder Name:	
Policy Holder Relationship to Patient:	
Policy ID Number:	Group Number:
Claim Address/City/State/Zip	

Household Members

(List all individuals that live in your household **STARTING WITH YOU**)

Name	Age	Relation to Self
		Self

Household Monthly Income (GROSS)		Household Monthly Expenses	
Salary per Month	$	Rent ☐ Mortgage ☐	$
Social Security	$	Gas/Electric/Water	$
Pension/Annuity/Disability	$	Telephone	$
Rents/Royalties	$	Food/Groceries	$
Child Support/Alimony Received	$	Gas (Auto)	$
Interest/Dividends	$	Medications	$
Other (list):	$	Child Care (work related)	$
	$	Child Support	$
	$	Health Insurance	$
		Auto Insurance	$
		Homeowner's Insurance	$
TOTAL HOUSEHOLD MONTHLY INCOME	$	Life and/or Disability Insurance	$

	Lendor/Creditor	Balance	Monthly Payment
Auto Loan		$	$
Home Loan		$	$
Other Loan(s)		$	$
Medical Bills		$	$
Credit Cards		$	$
		TOTAL HOUSEHOLD MONTHLY EXPENSES $	

Household Assets			VALUE
Checking-Bank:	City:	State:	$
Checking-Bank:	City:	State:	$
Savings-Bank:	City:	State:	$
Savings-Bank:	City:	State:	$
Other Liquid Assets:	City:	State:	$
			$
Vehicle Model:		Year:	$
Vehicle Model:		Year:	$
Real Estate (market value)			$
Land (Including Farm Ground)			$
Other Assets (Description) i.e. boat, camper, livestock, etc.:			$
		TOTAL HOUSEHOLD ASSETS	$

STATUS OF MEDICAID ELIGIBILITY (Please Print/Sign)	
Applied for Medicaid? Yes ☐ No ☐	Pending ☐ Approved ☐ Denied (attach copy of denial letter) ☐
Spend Down (if applicable): $	

REQUIRED SIGNATURE FOR PROCESSING OF PATIENT FINANCIAL ASSISTANCE PROGRAM APPLICATION

I understand that this application for Patient Financial Assistance Program is confidential and will be used to determine my eligibility for uncompensated services under the guidelines established by MCHHS. I affirm the information provided is accurate and to the best of my knowledge. If any information that has been given proves to be untrue, I understand that MCHHS may re-evaluate my financial status and take whatever action becomes appropriate.

Signature of Responsible Party	Date:

To determine eligibility for Financial Assistance, application requires proof of income for ALL in the household which includes: copies of last three months of pay stubs, copy of most recent Social Security benefits letter, copies of last two filed tax returns (ENTIRE DOCUMENTS), copies of household bank statements (last two months for each account) along with IRA, 401 K, OR 401B statements, if applicable.