



APPLICATION FOR FINANCIAL ASSISTANCE

APPLICANT INFORMATION (PLEASE PRINT CLEARLY)			
Patient's Name:			
Address:			
City:	State:	Zip:	
Phone:	Cell Phone:		
Age:	Male/Female	Marital Status:	Date of Birth:
Employer:			
Health Insurance:		Eligible for Medicaid:	
APPLICANT EMPLOYMENT & INSURANCE INFORMATION			
Spouse/Partner Name:			
Phone:		Cell Phone:	
Age:	Male/Female	Marital Status:	Date of Birth:
Health Insurance:		Eligible for Medicaid:	
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 (Approximately)	
Gross Wages	\$	Rent / Mortgage	\$
Social Security (from Bank stmt)	\$	Gas/Electric/Water	\$
Pension/Annuity/Disability	\$	Telephone	\$
Rents/Royalties	\$	Food/Groceries	\$
Interest/Dividends	\$	Gas (Auto)	\$
Self Employment	\$	Medications	\$
Other (list):	\$	Child Care (work related)	\$
	\$	Health Insurance	\$
	\$	Auto Insurance	\$
	\$	Homeowner's Insurance	\$
	\$	Life/Disability Insurance	\$
TOTAL	\$	TOTAL	\$



	Monthly Payment
Auto Loan:	\$
Home Loan:	\$
Other Loan(s):	\$
Medical Bills:	\$
Credit Cards:	\$

TOTAL \$

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	\$

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: 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, most recent Federal Income Tax Return with Schedules, and last two months of bank statements.