Minnie Hamilton Health System

FINANCIAL ASSISTANCE APPLICATION FOR ELIGIBILITY DETERMINATION

IDENTIFYING INFORMATION:

Patients Name: ____ Phone Number: ____________________

Address: ______________________ City: __________________ State: _________ Zip Code: ______________

SSN: ____________________________________ Date of Birth: _______________________________________

Financial Assistance Requested by: ____________________________ Relation: ___________________________

List Family Members: (Living In Household)

____ Age: _________ Occupation: ________________________

____ Age: _________ Occupation: ________________________

____ Age: _________ Occupation: ________________________

____ Age: _________ Occupation: ________________________

____ Age: _________ Occupation: ________________________

INCOME/EXPENSE INFORMATION:

Patient's Employer: ______________________________________ Phone Number: _______________________

Employer Address: _______________________________________ How long employed? ____________________

Occupation: ____

(Circle One): Actively Employed Retired Disabled Full Time Student Laid Off

Guarantor/Spouse Employer: ________________________________ Phone Number: ________________________

Have you or spouse (guarantor) filed for bankruptcy? ________ If so, when and what type: ______________________

PREVIOUS WORK HISTORY:

List last 3 Employers with the most recent first. DO NOT include employer listed above.

Employer: _______________________ Addr.: ____________________________ How long employed: _________

Reason for leaving: ____

Employer: _______________________ Addr.: ____________________________ How long employed: _________

Reason for leaving: ____

Employer: _______________________ Addr.: ____________________________ How long employed: _________

Reason for leaving: ____

List Gross Monthly Income	**Last 3 Mths**	**Last 12 Mths**
Wages (Self)		
(Spouse)		
(Other Family Members)		
Farm or Self Employment		
Public Assistance/AFDC		
Social Security/Disability Income		
Food Stamps		
Unemployment Compensation		
Workers Compensation		
Alimony		
Child Support		
Pensions		
Dividends, Interest, Rental Income		
Other		
Total Income	$	$

You will need to apply for a Medical Card
Once you have done so, we will need a copy of your denial letter
Please complete and return this form.

Are you on our Sliding Fees Program?
Yes ( ) No ( )
If No you need to apply for this program.

NET WORTH:

Do you own or rent home? ( ) own ( ) rent. If own home: value owed $___________ value of home $ _______________

Do you or spouse own automobiles (including recreational vehicles)? ( ) yes ( ) no

Model/Make Year (include recreational vehicle) Value owed Value

____

____

____

LIST ALL DEBS OWED IN EXCESS OF $100.00

To Whom Indebted	Addr./Location	Type of Acct.	Current Balance	Payment Current	Monthly Payment
1. (Mortgage)					
2. (Auto)					
3. (Auto)					
4. (Banks/Finance)					
5. (Credit Cards)					
6. (Credit Cards)					
7. (Medical Bills)					
8. (Other)					
9. (Other)					

MONTHLY EXPENSES:

Utilities $________________
Food $________________
Telephone $________________
Cable/Satellite $________________
Home Insurance $________________
Auto Insurance $________________
Other $________________

TOTAL $________________

LIST ACCOUNTS TO CONSIDER

Patient's Name	Acct #	DOS	Balance

REFERENCES: CK ACCT# Savings #
Bank Name/Branch: ______________________________________
Bank Name/Branch: ______________________________________
CD/IRA Accounts: ______________________________________

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make an application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for the hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate. I authorize Minnie Hamilton Health Care to contact the employers and institutions on the application to verify its accuracy. I further authorize the employers/institutions to release such information to Minnie Hamilton Health Care Center.

______________________________________ ______________________________________
Applicant's Signature Date of Request

SUBMIT PROOF OF INCOME WITH THIS APPLICATION FOR ALL FAMILY MEMBERS OVER THE AGE OF 18 IN YOUR HOME.

FOR OFFICIAL USE ONLY
( ) APPROVED DATE OF APPROVAL ________________ AMOUNT REWARDED ________________
( ) DENIED DATE OF DENIAL ___________________ REASON FOR DENIAL ________________

COMMENTS: ____
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