

MONROE COUNTY HOSPITAL APPLICATION FOR FINANCIAL ASSISTANCE

Date of Application:		<small>MCH Use Only.</small>	
Patient Information (Please complete below)			
Name:		SS #:	Birthdate:
Address:		Phone #.:	
Employer Name:	# of Hours Worked/Wk:	Phone #.:	
Hourly Wage or Yearly Salary:		Monthly Social Security or Disability, SSI:	
Other Income and Source:			
Spouse/Parent Information (Please complete below)			
Name:		SS #:	Birthdate:
Address:		Phone #.:	
Employer Name:	# of Hours Worked/Wk:	Phone #.:	
Hourly Wage or Yearly Salary:		Monthly Social Security or Disability, SSI:	
Other Income and Source:			
Guarantor/Responsible Party Information (Complete only if different from Patient or Spouse/Parent)			
Name:		SS #:	Birthdate:
Address:		Phone #.:	
Employer Name:	# of Hours Worked/Wk:	Phone #.:	
Hourly Wage or Yearly Salary:		Monthly Social Security or Disability, SSI:	
Other Income and Source:			
Name, Age, and Income of All Other Household Members (Use the back of this form if needed for additional members)			
Name:		Age:	Income and Source:
Name:		Age:	Income and Source:
Name:		Age:	Income and Source:
Financial Information (Please complete below)			
Do you own or rent your home? _____ Own _____ Rent		Monthly Payment or Rent Amount:	
Please list the amounts from your last bill for all of the following: Electricity: Water:			
Gas: _____	Telephone: _____	Do you receive Food Stamps? <input type="checkbox"/> x <input type="checkbox"/> No <input type="checkbox"/> Yes, \$ _____ /month	
Are you currently receiving Medicaid benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, skip the rest of this section.</i>			
Have you applied for Medicaid within the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, was your application denied? <input type="checkbox"/> No, pending <input type="checkbox"/> Yes			
If Yes, why were you denied?			

Please list the total of all outstanding medical bills you have.		Do you have any medical insurance?	
Please list all banks or credit unions you do business with.			
Checking account balance(s)		Savings account balance(s)	
Do you own a vehicle(s)? ___ No ___ Yes		If Yes, what is your monthly payment(s)?	

I certify that the above information is true to the best of my knowledge and that it is subject to verification by Monroe County Hospital. Further, I will make application for any assistance (Medicaid, Medicare, insurance, etc.) which may be available for payment for my hospital bill. I will also take any action necessary to obtain such assistance and will assign or pay to Monroe County Hospital the amount recovered for hospital charges. I understand that this application is made so the Monroe County Hospital can judge my eligibility for uncompensated services, based on the established criteria on file. If any information I have given proves to be untrue, I understand Monroe County Hospital may reevaluate my financial status and take whatever action becomes appropriate.

Patient Signature

Date

Guarantor/Spouse/Parent Signature

Date