APPROVED _____ INDIGENT_____% CHARITY_____DENIED_____DATE_____

Memorial Hospital and Manor **Financial Assistance Request Application**	Memorial Hospital and Manor will not Discriminate against any patient because of race, creed, national origin, physical disability or because the patient is covered by a particular program or insurance.

I hereby request the hospital to make a determination of my eligibility for financial assistance.

Name: _____ **Date of Birth: _____**

Address: _____ **Employer: _____**

City, State, Zip: _____ **Social Security #: _____-_____-_____**

Telephone Number: _____

Marital Status: Married () Divorced () Widowed () Single () Legally Separated ()

Spouse Name _____ **Spouses SS# _____**

Spouse Employer _____ **Spouses Date of Birth_____**

Dependents (with whom you provide half or more of their support**)**

Name	Social Security	Date Of Birth	Relationship
		/ /	Daughter or Son
		/ /	Daughter or Son
		/ /	Daughter or Son

Earned Income _____

Frequency _____

Other Income _____

Type_____

Checking () savings () Life insurance Policy () Property ()

Additional Information: _____

Expenses

Food: _____

Phone: _____

Light: _____

Water: _____

Car Insurance: _____

Rent () Mortgage () Own () Payment Amount: _____

Car Payment () Payment amount: _____

Amount Owed to the Hospital: _____

Medical Insurance Company Name/Policy Number: _____

Should the patient/guarantor be eligible for partial financial assistance, the balance of the account will be due in full unless satisfactory payment arrangements are made in compliance with Memorial Hospital and Manor's policy. I affirm the above information is true and correct to the best of my knowledge. Should it be determined that financial assistance has been provided based on false or incorrect information contained in the application, I understand that the assistance provided may be reversed and may lead to legal recourse. I hereby authorize Memorial Hospital and Manor to render the above information provided to any government agency as it may be required to substantiate any obligation for uncompensated services.

Signature of Patient/Guarantor Date

Witness Date