



ASSISTANCE APPLICATION

To be considered for the Assistance Program, please complete the following application completely and accurately. The following items are **REQUIRED** (if applicable) to be considered for the Assistance Program. Please provide COPIES of the applicable following documents with your application:

****PLEASE ONLY SEND COPIES OF YOUR INFORMATION****

<u>Enclosed</u>	<u>Document</u>
_____	Federal Tax Return (Last Filed)
_____	3 Months of Bank Statements (all accounts)
_____	1 Month of Payroll Stubs for each working member of household
_____	Social Security Notice
_____	Unemployment Compensation Notice

The above documents will be used to make a final determination for Assistance. The Assistance Program determines eligibility based on total household income. **If living with any income earner, including parents, significant others, etc, please include their income information as well.**

Any incomplete application will be denied.

Please return this application within 30 days to:

MCHI
Attn: Patient Accounts
1423 7th St
Aurora, NE 68818



PATIENT FINANCIAL INFORMATION

Responsible Party Information

Name: _____ Address: _____
City: _____ State _____ Zip _____
Home Phone: _____ Cell Phone: _____
Social Security Number: _____ Marital Status: _____

Current Employer: _____ Length of Employment: _____
Gross Salary: \$ _____ Monthly (include pay stubs)

Previous Employer: _____ Length of Employment: _____

Other Gross Income Per Month (provide all applicable):

Social Security: _____ Unemployment Comp: _____
Child Support: _____ Alimony: _____ Work Comp: _____
Pension: _____ Interest: _____ Self Empl: _____
Rents Received: _____ Other(please specify): _____

Number of Dependent Children (in household): _____

Spouse/Other Household Information

Name: _____ Social Security #: _____

Current Employer: _____ Length of Employment: _____
Gross Salary: \$ _____ Monthly (include pay stubs)

Previous Employer: _____ Length of Employment: _____

Other Gross Income Per Month (provide all applicable):

Social Security: _____ Unemployment Comp: _____
Child Support: _____ Alimony: _____ Work Comp: _____
Pension: _____ Interest: _____ Self Empl: _____
Rents Received: _____ Other(please specify): _____

ASSETS

****Attach copies of current statements****

Cash on Hand	\$ _____	CD's	\$ _____
Checking Balance	\$ _____	Investments	\$ _____
Savings Balance	\$ _____	Rental Property	\$ _____
Home (Market Value)	\$ _____	Land (Ag, other)	\$ _____

Automobile(s):

#1	Year _____	Make _____	Value: _____
#2	Year _____	Make _____	Value: _____
#3	Year _____	Make _____	Value: _____

Other Assets – Boats, Motorcycles, Camper, ATV, etc (please list with values):

LIABILITIES

<u>Type of Liability</u>	<u>Unpaid Balance</u>	<u>Monthly Payment</u>	<u>Purpose of Loan</u>
Mortgage Loan:			
Bank Loans:			
Finance Companies:			
Credit Cards:			
Collection Agencies:			

LIABILITIES (cont)

<u>Type of Liability</u>	<u>Unpaid Balance</u>	<u>Monthly Payment</u>	<u>Purpose of Loan</u>
Medical Bills:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other Liabilities(specify):	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

MONTHLY EXPENSES

Housing: Buying	\$ _____	Phone/Internet	\$ _____
Rent	\$ _____	Cell Phone	\$ _____
Food	\$ _____	Water/Sewer	\$ _____
Clothing	\$ _____	Child Care	\$ _____
Car Expenses	\$ _____	Natural Gas	\$ _____
Car Insurance	\$ _____	Electricity	\$ _____
Medicine	\$ _____	Cable	\$ _____
Health Insurance	\$ _____	Other:	
		_____	\$ _____
Life Insurance	\$ _____	_____	\$ _____
		TOTAL	\$ _____

ADDITIONAL INFORMATION

If you expect changes in income, health or other circumstances, or cannot provide the requested information, please explain. Also, please provide us with any other comments you have regarding your application.

I (we) certify that the information provided is true and accurate to the best of my (our) knowledge. I (we) hereby authorize Memorial Community Health, Inc. and or its agents to verify the information provided in this application. I (we) hereby authorize that verification can include, but not limited to, the inquiry of my (our) credit history through a credit reporting agency. If any of the information given proves to be untrue, that I (we) understand that the application will be denied.

Print Name

Print Name

Signature

Signature

Date

Date