Memorial Medical Center

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Financial Assistance Policy

Appendix D: Financial Assistance Request Form

I. Patient Information

PATIENT'S NAME LAST	FIRST	MI	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY STATE	ZIP	PRIMARY CARE PHYSICIAN
DATE OF BIRTH / TELEPHONE - HOME	TELEPHONE - WORK		TELEPHONE - CELL

II. Guarantor Information

NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL	RELATIONSHIP	Please check this box if you are applying to pre-qualify ☐
STREET ADDRESS	CITY STATE ZIP	SOCIAL SECURITY NUMBER
DATE OF BIRTH / TELEPHONE - HOME	TELEPHONE - WORK	TELEPHONE - CELL

III. Household Information – Please indicate ALL people living in your household, including applicant (use additional paper, if necessary)

HOUSEHOLD MEMBERS FIRST AND LAST NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	EMPLOYER NAME	YEAR TO DATE INCOME	INSURED? IF YES, LIST INSURANCE (I.e. Blue Cross, Medica, etc.)
1.					Yes ☐ No ☐
2.					Yes ☐ No ☐
3.					Yes ☐ No ☐
4.					Yes ☐ No ☐

IV. EMPLOYER		SALARY WEEKLY $
V. SPOUSE'S EMPLOYER		SALARY WEEKLY $
VI. OTHER INCOME		AMOUNT $

VII. Expenses and Assets

Rent/mortgage payment $	Checking account balance $	Health Insurance Premium $
Mortgage loan balance $	Savings account balance $	Other Assets $
Real market value of home $	Stocks, bonds, CDs, etc. $	Monthly Food Costs $
Real estate other than primary $	Recreational vehicles $	Child Support received/paid $

Please feel free to attach additional information regarding your current situation.

VIII. Required Documentation – Information that must be sent with this application

Please check that you have included the following:

☐ * Copy of previous year's tax returns	☐ Copy of latest bank statements	☐ Income verification showing earnings or pay stubs for all income year-to-date

We may require additional documentation in order to assist you. If so, we will contact you at the telephone numbers you have listed. If you have questions regarding this form, please call 715-685-5500.

* Please note: If your parent or someone else provides your basic living support, you must include their tax and income information.

IX. Authorization

I hereby certify the information contacted in the above financial questionnaire is correct and complete to the best of my knowledge. I authorize Memorial Medical Center to verify any or all information given.

RESPONSIBLE PERSON'S SIGNATURE _____ DATE _____

FORM #2559