



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
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 <input type="checkbox"/>
STREET ADDRESS		CITY		STATE	ZIP
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 <input type="checkbox"/> No <input type="checkbox"/>
2.					Yes <input type="checkbox"/> No <input type="checkbox"/>
3.					Yes <input type="checkbox"/> No <input type="checkbox"/>
4.					Yes <input type="checkbox"/> No <input type="checkbox"/>
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 \$	
<i>Please feel free to attach additional information regarding your current situation.</i>					
VIII. Required Documentation – Information that must be sent with this application					
Please check that you have included the following:					
<input type="checkbox"/> * Copy of previous year's tax returns		<input type="checkbox"/> Copy of latest bank statements		<input type="checkbox"/> 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 _____	