FINANCIAL ASSISTANCE PROGRAM APPLICATION

Name: _____ Date of Birth: _____ Telephone Numbers

Address: _____ Home: _____

City/State/Zip: _____ Work: _____

Spouse's Name: _____ Date of Birth: _____ Cell: _____

Employed: Y/N Unemployed: Y/N Retired: Y/N

Name & Date of Birth of **ALL** Dependents of Household (Full time Students under age 25)

Name: _____ DOB _____ Name: _____ DOB: _____

Name: _____ DOB _____ Name: _____ DOB: _____

Name: _____ DOB _____ Name: _____ DOB: _____

PROOF OF INCOME: SUMBIT APPLICABLE PROOF OF INCOME LISTED BELOW

□ Federal Tax Return (most recent) REQUIRED

□ Social Security □ VA Assistance □ Pension/ Retirement □ Alimony

□ Disability □ Life Insurance □ Public Assistance □ Other: Please List _____

□ Unemployment □ Workman's Comp. □ Child Support

ASSETS

Cash on Hand (including Checking) $ _____

Savings $ _____

Vehicles: Value

Model _____ YR _____ $ _____

Model _____ YR _____ $ _____

Other Assets _____ $ _____

Insurance Information

Name: _____

Policy #: _____

Covered Members:

_____

_____

_____

_____

Prescription Expenses

Monthly: _____

I understand that I assume full responsibility for the accuracy of the statements on this form, and I understand that Madison County Memorial Hospital will use these statements to determine my eligibility for the Financial Assistance Program.

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Applicant _____ Date _____

If you have any questions regarding this form, please contact the Business Office Manager at 515-462-9738