



Mineral Community Hospital

Here when you need us

HEALTHCARE FINANCIAL ASSISTANCE APPLICATION

General Information	Date Received (Office Use Only)
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ACCT # _____

Patient Name _____

Last 4 digits of Social Security _____ Date of Birth _____

Please Circle One: Single Married/Significant Other Divorced/Separated Widow/Widower

Spouse/ Guardian _____ ACCT # _____

Last 4 digits of Social Security _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ County _____

Patient Home Ph # _____ Cell Ph # _____ Work Ph # _____

Spouse/Guardian Home Ph # _____ Cell Ph # _____ Work Ph # _____

Email _____

Name(s) and age(s) of dependents living with you for whom you are responsible. Please include DOB:

Monthly Income	Yours		Spouse	
Gross Pay				
Alimony/Child Support				
Social Security				
Unemployment/Work Comp				
Retirement/Pension				
Interest/Rental				
Other				
Monthly Total				

Additional information if needed:

ACCT #

Current Employer _____
 Address _____
 Phone # _____ Occupation _____
 Length of Employment _____ Years _____ Months _____ Full Time / Part Time
 Number of hours scheduled to work each week _____
 If unemployed, date of unemployment _____ Are you receiving unemployment? Yes / No
 If Yes – Beginning Date _____ Amount receiving weekly _____
 Spouse/Significant Other’s Employer _____
 Address _____
 Phone # _____ Occupation _____
 Length of Employment _____ Years _____ Months _____ Full Time / Part Time
 Number of hours scheduled to work each week _____
 If unemployed, date of unemployment _____ Are you receiving unemployment? Yes / No
 If Yes – Beginning Date _____ Amount receiving weekly _____

Other Assistance

Do you receive food stamps? _____ Yes _____ No
 Do you have medical benefits? _____ Yes _____ No
 If no, have you applied for Medicaid? _____ Yes _____ No Date Applied _____
 If benefits were denied, what reason was given? _____
 Date Medicaid was denied _____

***Medicaid application and/or denial will not be used to determine eligibility for sliding fee scale.

Your signature is required below:

My signature attests that the information I provided within this form is accurate and true to the best of my knowledge. I understand that MCH requires verification of income before any determination can be made.

Signature _____ Date _____

Required Documentation: Only provide applicable Income Documentation.

- Completed, signed and dated Healthcare Financial Assistance Application
- 3 months of pay stubs for you, spouse and/or significant other (Copies)
- 3 months of bank statements (Copies)
- Award letter(s) for unemployment, social security, pension, etc. (Copies) – Must display monthly benefit
- Child Support/Court Ordered Maintenance
- Prior year’s tax return Form 1040(Copy) – Cannot accept W2 Forms
- If unemployed and/or living with friend or family, please explain on Page 1 – space provided or attach a page.
- If self-employed, please provide business ledger for last 3 months (Copies)

Please note: **We will deny applications that are incomplete** and do not include the above listed required documentation.