Mineral Community Hospital

Here when you need us

HEALTHCARE FINANCIAL ASSISTANCE APPLICATION

General Information	**Account # ________________**	**Date Received (Office Use Only)**

Patient Name ____

Date of Birth ____________________________

Address ____

City __________________________ State __________ Zip _________ County _____________

Patient Home Phone # _____________ Cell Phone ________________ Work Phone _____________

Email ____

Spouse/Guardian ____

Date of Birth ____________________________

Address ____

City __________________________ State __________ Zip _________ County _____________

Patient Home Phone # _____________ Cell Phone ________________ Work Phone _____________

Email ____

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

____

____

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:

____

____

____

Current Employer ___________________________________ Phone # ______________________________

Address ____

Occupation ________________________________ Length of Employment _________ Years ________ Months

Full Time or Part time Number of hours scheduled to work each week ____________________________

If unemployed, date of unemployment _____________________ Are you receiving unemployment? Yes or No

If Yes – Beginning Date ________________________________ Amount receiving weekly __________________

Spouse/Significant Other Current Employer ____________________________ Phone# ________________

Address ____

Occupation ________________________________ Length of Employment _________ Years ________ Months

Full Time or Part time Number of hours scheduled to work each week ____________________________

If unemployed, date of unemployment _____________________ Are you receiving unemployment? Yes or No

If Yes – Beginning Date ________________________________ Amount receiving weekly __________________

Other Assistance

Do you receive food stamps? Yes or No Do you have medical benefits? Yes or No

If no, have you applied for Medicaid? Yes or 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 have 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.
- 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.