



FINANCIAL ASSISTANCE APPLICATION

Date _____

Section 1

Carroll County Memorial Hospital is dedicated to the health and well-being of all we serve and Financial Assistance is available to provide help with medical bills for patients who demonstrate a financial need. If you are interested in applying for assistance, please complete this application and return to Patient Financial Services or contact the billing office to set up an appointment to get assistance on filling out the application with the Patient Advocate on staff.

Guarantor _____ Patient Name: _____

Spouse Name: _____

Address _____ City _____ St _____ Zip _____

SSN# _____ Hm Phone _____ Wk _____ Cell _____

I am Retired Unemployed Disabled

Are you or your spouse presently employed? Patient: Part Time: _____ Full Time: _____
 Spouse: Part Time: _____ Full Time: _____

Patient's current employer : _____
 Employer Address : _____ city/st/zip _____
 Employer Phone : _____ Length of employment: _____ mo/yr

Spouse's current employer: _____
 Employer Address : _____ city/st/zip _____
 Employer Phone : _____ Length of employment: _____ mo/yr

If Unemployed, List past employment:

Patient	Spouse
Employer: _____	_____
Address: _____	_____
City/St: _____	_____
Phone: _____	_____

Date last employed: _____



Section 2

I hereby acknowledge that I have previously applied for:

Medicare Date of application _____ Accepted (Date of Eligibility) _____
 Denied*

Medicaid Date of application _____ Accepted (Date of Eligibility) _____
 Denied**

*If determined to be ineligible for any benefits, reason stated was: _____

**** Please attach a copy of the denial letter from Division of Family Services.**

Note: Application(s) for Medicare/Medicaid must have been made no less than 60 days prior to or 30 days after the date service was rendered at Carroll County Memorial Hospital.



INCOME

Section 3

Monthly Income

Wages \$ _____
 Public Assistance/Food Stamps \$ _____
 Alimony/Child Support \$ _____
 Social Security \$ _____
 Self Employment/Farming \$ _____
 Unemployment Compensation \$ _____
 Workman's Compensation \$ _____
 Income from (Rental properties, Dividends, Interest) \$ _____
 Other (Military Allotment, Etc...) \$ _____
 Monthly Income \$ _____

EXPENSES

Monthly amount

Section 4

House Rental/ Payment \$ _____
 Food \$ _____
 Car Payment \$ _____
 Phone/Cable \$ _____
 Electric \$ _____
 Gas \$ _____
 Water/Sewer \$ _____
 Other Medical expense \$ _____
 Other (Credit cards, past loans, Specify please) \$ _____
 Total Expenses: \$ _____

FAMILY SIZE

Section 5

**As reported on last year's income tax return*

Family Member Name(s)	Relationship to Patient	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Section 6

TYPE OF MEDICAL SERVICE NEEDED OR REQUESTED

- Emergency Dept Inpatient Services Outpatient Services
- Home Health Medical Clinic Other (please specify)_____

Date or Expected date for services to be rendered_____

Section 7

Please attach supporting documentation or supporting evidence of **ALL Income & Expense** information. Examples are: W-2's, Payroll Stubs, 1099's, Monthly Utility Bills, loans outstanding, credit card or medical debt and other documentation to support the Financial Assistance Process.

****Include a copy of LAST Year's Income Tax Return**, if you did not file a return please specify why and the last time income was reported.

Tax Information enclosed for 2017: Yes_____

Tax information NOT enclosed: No_____ Reason why, state below.

Section 8

ADDITIONAL COMMENTS:

*Any extenuating circumstances, financial, personal or life changing events you would like to explain here:



Section 9

I HEREBY AFFIRM that the above information is correct to the best of my knowledge.
If such information is found to be incorrect or has been falsified, I may be denied eligibility.

Signature of patient making request or authorized individual

Date