CCMH

CARROLL COUNTY MEMORIAL HOSPITAL

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:	_____	_____

1502 North Jefferson Street, Carrollton, Missouri 64633
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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.

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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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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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 2015: Yes____

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

_____

_____

Section 8

ADDITONAL COMMENTS:

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

_____

_____

_____

_____

_____

_____

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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

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