CCMH
CARROLL COUNTY MEMORIAL HOSPITAL

Financial Assistance Application

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 (excludes medical bills from other parties) 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. If you need assistance with the application, please contact the Patient Advocate at 660-542-1695 ext. 3013 to set up an appointment.

Section 1

Application Date: _____

Guarantor: _____ Patient Name: _____

Spouse Name: _____

Address: _____ City: _____ St: ____ Zip: _____

SSN # (optional)_____ Home Phone #: _____

Work Phone #: _____ Cell Phone #: _____

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: _____ month(s) / year(s)

Spouse's Current Employer:_____

Employer Address: _____ City/St/Zip: _____

Employer Phone #:_____ Length of Employment: _____ month(s) / year(s)

If Unemployed, List Past Employment:

Patient	Spouse
Employer: _____	Employer: _____
Address: _____	Address: _____
City/St/Zip: _____	City/St/Zip: _____
Phone #: _____	Phone #: _____
Date Last Employed: _____	Date Last Employed: _____

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Section 2
*****(ONLY APPLICABLE FOR APPLICATIONS OVER 200% FPL)

I hereby acknowledge that I have previously applied for:

☐ **Medicare**

Date of Application: _____

☐ Accepted

☐ Denied If determined to be ineligible for any benefits, reason stated was:

_____

_____

_____

_____

_____

_____

_____

☐ **Medicaid**

Date of Application: _____

☐ Accepted

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

PLEASE NOTE: Application(s) for Medicare/Medicaid must be 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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Section 3

Income

	Monthly Income
Wages	$_____
Public Assistance	$_____
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 $_____

Section 4

*****(ONLY APPLICABLE FOR APPLICATIONS OVER 200% FPL)

Expenses

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

Total Expenses $_____

Section 5

Family Size

**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

*******(ONLY APPLICABLE FOR APPLICATIONS OVER 200% FPL)**

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**

Tax Information enclosed for most recent year.

☐ Yes

☐ No Last Time Income Reported:_____

Reason why: _____

_____

_____

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.

_____ _____

Patient/Patient's Authorized Representative Signature **Date**

_____

Relationship to Patient