



FINANCIAL ASSISTANCE

Date of Request: _____

Patient Name: _____

Address: _____

Number of persons in family: _____

Acct # / Amt _____ Date _____

Phone: _____

Name of family members	Age	Relationship	Employment / Income Info
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1. _____

2. _____

3. _____

4. _____

5. _____

You Must Provide Verification

Family Income last three (3) months: \$ _____

Financial Assets (checking, savings, HSA, etc): _____

Do you have any insurance to pay hospital charges: Yes No

If yes, name of insurance: _____

Government Benefits:

Food Stamps _____

Housing Yes No

Health Card Yes No

Utilities Yes No

I understand that the information I submit is subject to verification by Perry County Memorial Hospital and subject to review by others as required. I swear that the above information is true and correct. I also understand that the Financial Assistance Program provides services for in-patient and out-patient services.

Signature of Applicant _____

Relationship to patient (if applicable) _____

FOR COMPLETION BY HOSPITAL PERSONNEL ONLY

Application Received by: _____ Date: _____

The following documents are required to verify income and assets: _____

Deadline for submitting these documents: _____

You must actively pursue a claim from a third party insurer or governmental program for which you may be entitled benefits: HCI Medicaid Other: _____

Approved Denied Reason: _____

Authorized Signature _____

Date _____

THIS INSTITUTION IS AN EQUAL OPPORTUNITY EMPLOYER AND PROVIDER

DOB:
ADMIT:
ADM:
ATT:
MR #:

AGE:

HSV:
SEX:

#:
#:

PAT #:

