



**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 #:

