ASSISTANCE APPLICATION

To be considered for the Assistance Program, please complete the following application completely and accurately. The following items are **REQUIRED** (if applicable) to be considered for the Assistance Program. Please provide COPIES of the applicable following documents with your application:

****PLEASE ONLY SEND COPIES OF YOUR INFORMATION****

Enclosed	Document
_____	Federal Tax Return (Last Filed)
_____	3 Months of Bank Statements (all accounts)
_____	1 Month of Payroll Stubs for each working member of household
_____	Social Security Notice
_____	Unemployment Compensation Notice

The above documents will be used to make a final determination for Assistance. The Assistance Program determines eligibility based on total household income**. If living with any income earner, including parents, significant others, etc, please include their income information as well.**

Any incomplete application will be denied.

Please return this application within 30 days to:

MCHI
Attn: Patient Accounts
1423 7th St
Aurora, NE 68818

PATIENT FINANCIAL INFORMATION

Responsible Party Information

Name:_____ Address:_____
City:_____ State_____ Zip_____
Home Phone:_____ Cell Phone:_____
Social Security Number:_____ Marital Status:_____

Current Employer:_____ Length of Employment:_____
Gross Salary: $_____Monthly (include pay stubs)

Previous Employer:_____ Length of Employment:_____

Other Gross Income Per Month (provide all applicable):
Social Security:_____ Unemployment Comp:_____
Child Support:_____ Alimony:_____ Work Comp:_____
Pension: _____ Interest:_____ Self Empl:_____
Rents Received:_____ Other(please specify):_____

Number of Dependent Children (in household):_____

Spouse/Other Household Information

Name:_____ Social Security #:_____

Current Employer:_____ Length of Employment:_____
Gross Salary: $_____Monthly (include pay stubs)

Previous Employer:_____ Length of Employment:_____

Other Gross Income Per Month (provide all applicable):
Social Security:_____ Unemployment Comp:_____
Child Support:_____ Alimony:_____ Work Comp:_____
Pension: _____ Interest:_____ Self Empl:_____
Rents Received:_____ Other(please specify):_____

ASSETS

****Attach copies of current statements****

Cash on Hand	$_____	CD's	$_____
Checking Balance	$_____	Investments	$_____
Savings Balance	$_____	Rental Property	$_____
Home (Market Value)	$_____	Land (Ag, other)	$_____

Automobile(s):

#1	Year_____	Make_____	Value:_____
#2	Year_____	Make_____	Value:_____
#3	Year_____	Make_____	Value:_____

Other Assets – Boats, Motorcycles, Camper, ATV, etc (please list with values):

_____ _____

_____ _____

_____ _____

LIABILITIES

Type of Liability	Unpaid Balance	Monthly Payment	Purpose of Loan
Mortgage Loan:	_____	_____	_____
	_____	_____	_____
Bank Loans:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Finance Companies:	_____	_____	_____
	_____	_____	_____
Credit Cards:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Collection Agencies:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

LIABILITIES (cont)

Type of Liability	Unpaid Balance	Monthly Payment	Purpose of Loan
Medical Bills:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other Liabilities(specify):	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

MONTHLY EXPENSES

Housing: Buying $_____

Rent $_____

Food $_____

Clothing $_____

Car Expenses $_____

Car Insurance $_____

Medicine $_____

Health Insurance $_____

Life Insurance $_____

Phone/Internet $_____

Cell Phone $_____

Water/Sewer $_____

Child Care $_____

Natural Gas $_____

Electricity $_____

Cable $_____

Other:

_____ $_____

_____ $_____

TOTAL **$_____**

ADDITIONAL INFORMATION

If you expect changes in income, health or other circumstances, or cannot provide the requested information, please explain. Also, please provide us with any other comments you have regarding your application.

_____
_____
_____
_____
_____
_____
_____

I (we) certify that the information provided is true and accurate to the best of my (our) knowledge. I (we) hereby authorize Memorial Community Health, Inc. and or its agents to verify the information provided in this application. I (we) herby authorize that verification can include, but not limited to, the inquiry of my (our) credit history through a credit reporting agency. If any of the information given proves to be untrue, that I (we) understand that the application will be denied.

_____	_____
Print Name	Print Name
_____	_____
Signature	Signature
_____	_____
Date	Date