PCMH Perry County Memorial Hospital

FINANCIAL ASSISTANCE

Date of Request: _____

Patient Name: _____ **Acct # / Amt** _____ **Date** _____

Address: _____ _____ _____

Number of persons in family: _____ Phone: _____

Name of family members	**Age**	**Relationship**	**Employment / Income Info**
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: AGE: HSV:
ADMIT: SEX:
ADM: #:
ATT: #:
MR #: PAT #: