Please return to:
Patient Resource Advocate
c/o Margaret Mary Health
PO Box 226
321 Mitchell Ave.
Batesville, IN 47006

Financial Assistance Application

SECTION 1 – PATIENT INFORMATION

Patient Name_____ Date of Birth_____ SSN_____

Address_____ City_____ Zip Code_____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Marital Status ___Single ___ Married ___ Divorced ___ Separated ___Widow

SECTION 2 – GUARANTOR INFOMRATION (Individual responsible for the bill)

Guarantor Name_____ Date of Birth_____ SSN_____

Address_____ City_____ Zip Code_____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Employer Name_____ Employer Phone (____)_____

Employer Address_____

SECTION 3 – HOUSEHOLD INFORMATION (Include all individuals living in the household who are listed on the most recent tax filing)

Name	Date of Birth	Relationship

SECTION 4 – MONTHLY FAMILY INCOME (Include income for all family members listed above)

Type of Income	Guarantor	Spouse/Other
Gross Wages	$	$
Self-Employment Income	$	$
Social Security Income	$	$
Disability Income	$	$
Unemployment Income	$	$
Pension Income	$	$
Alimony/Child Support	$	$
Other Income (Explain)	$	$
Total Monthly Income	$	$

If there is no monthly family income, please provide a brief explanation related to how patient is supported financially:

_____

_____

_____

SECTION 5 – MONTHLY EXPENSES

Type of Expense	Monthly Amount
Rent/Mortgage	$
Utilities	$
Automobile Loan	$
Telephone/Cell Phone	$
Insurance (Auto/Home)	$
Credit Card	$
Food	$
Child Care	$
Medical	$
Pharmacy	$
Other	$
Total Monthly Expense	$

SECTION 6 – ASSETS

Do you own your own home: ____Yes ____No Estimated value of home $_____

Checking Account Balance(s) $_____ Savings Account Balance(s) $_____

Other Asset Balance(s): $_____ (CDs, Stocks, Bonds, Retirement Accounts, etc.)

SECTION 7 – INCOME VERIFICATION

Copies of supporting documentation must be submitted for all income in order for application to be considered.

Please attach a copy of at least one of the items listed below **for each source of income noted in section 4 above.**

- Prior year tax return, including copies of all W-2s (Please include entire return, with supporting schedules)
- Two most recent pay stubs
- Written verification of wages from employer(s)
- Award letter from Social Security
- Award letter for Unemployment
- Two most recent Bank Statements (checking, savings, investments, retirement, etc.)
- Two most recent Investment Statements (retirement, annuity, CD, etc.)
- Legal decree documenting tax dependent eligibility and court ordered income

Additional information to support need for assistance: _____

_____

_____

_____

SECTION 8 – SIGNATURE

I hereby certify that the information provided above as part of the Margaret Mary Health (MMH) Financial Assistance Application is true and accurate to the best of my knowledge. I understand that I may be contacted by an MMH representative to discuss this application or request additional documentation. I understand failure to complete the Financial Assistance Application in its entirety, including providing supporting documentation, will result in denial of financial assistance. Furthermore, I have exhausted all efforts to obtain assistance (Medicare, Medicaid, HIP, etc.) which may be available to cover services provided by MMH. Should potential assistance be identified, I will take any and all actions necessary to obtain such assistance.

I acknowledge that completion of the Financial Assistance Application does not guarantee any reduction in the amount due to MMH. I understand that I am responsible for any account balances not covered by or in partial by financial assistance.

Patient or Account Guarantor Signature: _____ Date: _____