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

Financial Assistance Application

Patient Name(s)_____

Account Number(s)_____

SECTION 1 – GUARANTOR INFORMATION (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_____

A SEPARATE FINANCIAL ASSISTANCE APPLICATION IS NOT REQUIRED FOR ALL INDIVIDUAL MMH ACCOUNTS. FINANCIAL ASSISTANCE WILL BE PROVIDED ON ALL ACCOUNTS WITH ABOVE GUARANTOR LISTED ON THE ACCOUNT.

PLEASE INCLUDE COPIES OF ANY CURRENT PATIENT STATEMENTS FOR INIDIVIDUALS LISTED IN SECTION 2 OF THIS APPLICATION.

SECTION 2 – HOUSEHOLD INFORMATION (Include all individuals living in the household who are listed on the most recent tax filing)

Name	Date of Birth	Relationship

SECTION 3 – 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 4 – 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 5 – 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 6 – INCOME VERIFICATION

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

Examples of acceptable documentation are defined below:

- Prior year tax return (all schedules), including copies of all W-2s, 1099s, SSI letters, etc. - **PREFERRED**
- Two most recent pay stubs (applicable when current year income changes significantly from previous year)
- 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 7 – 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: _____