

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:** _____