FINANCIAL ASSISTANCE APPLICATION

INSTRUCTIONS: Complete this form and see the Documentation Checklist for all required information and copies. Please call our Patient Financial Specialists with any questions at 715-743-8322 or 715-819-1087.

Guarantor/Patient: ______________________________ Birth Date: __________ Age: ________

Spouse/Significant Other: __________________________ Birth Date: __________ Age: ________

Address: ______________________ City: ________________ State: _____ Zip: ________

Phone(s): 1) __________ 2) __________ Best time to contact: __________ Email address: ______________

Other Household Members (List each by name) Number in household: _____

Name: ____________________ Age: _______ Name: ____________________ Age: _______

Name: ____________________ Age: _______ Name: ____________________ Age: _______

Name: ____________________ Age: _______ Name: ____________________ Age: _______

Name of current health insurance: ____

Policy and group number: ____

Employment Status:	**Guarantor/Patient** ❑ Full-time ❑ Part-time ❑ Lay off ❑ Temporary Leave ❑ Unemployed	**Spouse/Significant Other** ❑ Full-time ❑ Part-time ❑ Lay off ❑ Temporary Leave ❑ Unemployed
Primary/Last/Current Employer		
Business Address ……………..		
Business Phone ………………		
Occupation ……………………		
Start date of Employment …….		
End date of Employment ……..		

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I N COM E (Guarantor/Patient and Spouse/Significant Other)

Total household income from all sources before taxes —

(Check all that apply)	Guarantor/Patient Annual Amount	Spouse/Significant Other Annual Amount
❑ Wages	$	$
❑ Social Security	$	$
❑ Unemployment	$	$
❑ Retirement/Pension	$	$
❑ Tax Refund	$	$
❑ Alimony/Child Support	$	$
❑ Other	$	$

MONTHLY PAYMENTS

Regular Monthly Payments		*Estimated Monthly Payments*	
Rent or Mortgage	$	Utilities:	$
Alimony/Child Support	$	Insurance:	$
Auto Loan Payment	$	Phone:	$
Other Loan Payment	$	Credit Cards:	$

Please explain your current financial situation and why you are applying for financial assistance:

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I certify that the above information is accurate to the best of my knowledge and truly represents my current financial status. I authorize Memorial Medical Center to verify any information given on this financial assistance application.

______________________________ ______________

Signature of Guarantor or Patient Date