Citizens Memorial Healthcare

APPLICATION FOR FINANCIAL ASSISTANCE

☐ Hospital

YOUR LAST TAX RETURN, LAST (2) TWO BANK STATEMENTS AND LAST MONTH'S PAYSTUBS MUST ACCOMPANY THIS APPLICATION SEND COPIES OF ALL REQUESTED DOCUMENTS. DO NOT SEND ORIGINAL DOCUMENTS AS THEY WILL NOT BE RETURNED.

Please complete this form on your computer, print it out and return it with the required financial information to:
Citizens Memorial Hospital, Patient Accounts, 1500 N. Oakland, Bolivar, MO 65613

SECTION I - Personal Information

Patient Name (Last, First, MI)				Account #	
Date of Application	Date of Birth			Social Security #	
Street Address of Patient				Phone Number	
City State Zip Code				Monthly Gross Income $	
Do you have Medicaid?	☐ Yes	☐ No	Have you applied for Medicaid?	☐ Yes	☐ No
Name of Guarantor (if other than patient)					

SECTION II - Assets Criteria

Number in Family

Name	Date of Birth	Relationship

Assets Include:		
Cash	Savings Account	
Checking Account	Certificates or Deposits/I.R.A.	
Equity in Real Estate	1. Primary Residence	2. All other residence
3. Acreage: # of acres	Value of Acreage	Debt on Acreage
Other Assets (Treasury Bills, negotiable paper, Corporate stocks and bonds)		

	Total

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SECTION III - Income Criteria

Sources of Income	Amount	Week	Month	Year
A. Salary/Wages Before Deductions:		☐	☐	☐
B. Public Assistance:		☐	☐	☐
C. Social Security Benefits		☐	☐	☐
D. Unemployment & Workmen's Compensation		☐	☐	☐
E. Veteran's Benefits		☐	☐	☐
F. Alimony/Child Support		☐	☐	☐
G. Other Monetary Support		☐	☐	☐
H. Pension Payments		☐	☐	☐
I. Insurance or Annuity Payments		☐	☐	☐
J. Dividends/Interest		☐	☐	☐
K. Rental Income		☐	☐	☐
L. Net Business Income (self-employed/ verified by independent source)		☐	☐	☐
M. Other (strike benefits, training stipends, military family allotment, income from estates & trusts)		☐	☐	☐
Total		☐	☐	☐

SECTION IV - Certification By Applicant

I understand that the information which I submit is subject to verification by the appropriate health care facility and the Federal or State governments. Willful misrepresentation of these facts will make me liable for all charges and

I understand that the information which I submit is subject to verification by the appropriate health care facility and the Federal or State governments. Willful misrepresentation of these facts will make me liable for all charges and subject to civil penalties.

If so requested by the health care facility, I will apply for governmental or private medical assistance for payment of the bill.

I agree to permit the health care facility to have access to tax returns, bank statements and to run a credit bureau report.

I certify that the above information regarding my family size, income, and assets is true and correct.

I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets.

Signature of Patient or Guarantor	Date

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