Mary Greeley MEDICAL CENTER

Patient Account#_____

MARY GREELEY MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION

Entire Application Must Be Completed

Patient/Guarantor Name _____

Patient Name (if different from guarantor) _____

GROSS MONTHLY INCOME OF ALL MEMBERS OF HOUSEHOLD

$_____ Wages
$_____ Social Security/Disability
$_____ Unemployment
$_____ Child Support/Alimony
$_____ Other – Please Describe: _____

$_____ Pension/Retirement
$_____ Annuity/Dividends
$_____ Student Loans
$_____ Cash from Relatives

$_____ TOTAL INCOME

Please describe your personal situation and reason for requesting assistance. If you currently display no income, please describe how you provide for your everyday living expenses such as housing, food, clothing, etc.:

_____
_____
_____
_____
_____
_____

	Applicant Information:	**Spouse/Significant Other Information:**
Name:		
Address:		
City/State/Zip:		
Phone Number:		
Email Address:		
Soc. Sec. No.:		
Date of Birth:		
Employer:		
Date of Hire:		
Hrs.Worked per Wk:		

Family Members (in household)	**Birth Date**	**Relationship**

Patient Account#_____

NEEDED DOCUMENTATION

You must return copies of the following documents with this application. **Please do not send original documents as they cannot be returned.** If you need copies made, we will be happy to assist.

All applicant (and spouse if applicable) information required

_____ Proof of Income – last 3 paycheck stubs or letter from employer

_____ Last filed Federal Tax Return

_____ Last 3 complete bank statements for checking, savings, stocks, bonds, annuities, etc., showing all transactions

_____ Annual Social Security Benefit Letter (if applicable)

_____ Pension Benefit Document (if applicable)

_____ Other document(s) requested by Financial Counselors:

_____

I have read and understand the above conditions to receive financial assistance. I also understand all the information on this application will be verified by the staff at Mary Greeley Medical Center and this will serve as a release for income verification and as a release to investigate my credit history. I swear all statements in this application are true and correct. If any information submitted is found to be false, it shall be cause for denial of this application and revocation of any previous financial assistance.

_____ _____

Signature of Applicant **Date**

Please return form and all documentation to: **Please return by: _____**

Financial Counselors
Mary Greeley Medical Center
P. O. Box 863
Ames, IA 50010
Phone: 515-239-2111
Fax: 515-956-2813
FinancialCounselors@mgmc.com