612 S. Sibley Ave.
Litchfield, MN 55355
(320) 693-4500
meekermemorial.org

Financial Assistance Application

Instructions:
If you have not yet discussed your financial situation with Patient Financial Services, please do so prior to completing this form. This information will help us assess your financial situation and determine your ability to pay for services provided by Meeker Memorial Hospital and Clinics. Note that until your financial statement has been reviewed and approved by our Patient Financial Services staff, you will be financially responsible for your medical care.

In addition to the completed financial statement, you will also be asked to supply the following:

- Income tax returns, (previous 2 years)
- Copies of recent pay stubs (two months)
- Social Security Benefit Statement (if applicable)

General Information

Patient ______________________________
Patient Registration Number______________________
Phone Number______________________________
Social Security Number__________________________
Address______________________________
____

Have you ever received financial assistance for a previous visit?
Are you a full-time student?______ Are you a part-time student?__________ School:__________________________

Spouse/Responsible Party

Name______________________________
Registration Number__________________________
Phone Number______________________________
Social Security Number________________________
Responsible Party (if under 18, complete for both parents)
Name______________________________
Registration Number__________________________
Phone Number______________________________
Social Security Number________________________
Explain______________________________

Employer Information - Patient

Employer______________________________
Employer Address__________________________
Phone Number______________________________
Job Title______________________________
Length of Employment________________________

Employer Information – Spouse/Responsible Party

Employer______________________________
Employer Address__________________________
Phone Number______________________________
Job Title______________________________
Length of Employment________________________

Dependents

Name	Age

Bank

Bank Name______________________________
Bank Address______________________________
Checking Account Number______________________
Balance $__________________________
Savings Account Number_______________________
Balance $__________________________
Other Investments and Securities__________________
____

Property/ Assets

	Estimated Value	**Unpaid Balance**
Residence: Own________ Rent__________		
Monthly Payments $__________________		
Residence …………………………………….	$__________________	$__________________
Vehicles		
Year/Make__________________	$__________________	$__________________
Year/Make__________________	$__________________	$__________________
Land: # of acres ……………………………………..	$__________________	$__________________
Business……………………………………………….	$__________________	$__________________
401K, IRA, Retirement ………………………………	$__________________	$__________________
Other:__________________________	$__________________	$__________________

Monthly Income

	Source	Monthly Income
1. Patient/parent if under 18	______________________	$______________
2. Spouse/Responsible Party	______________________	$______________
3. Interest/Dividends	______________________	$______________
4. Pension/Disability	______________________	$______________
5. Child Support/Alimony	______________________	$______________
6. Other	______________________	$______________

7**. Total Gross Monthly Income** (add lines 1 through 6) ………………………..... $______________

Monthly Expenses

	Average Monthly Expense
10. Groceries ………………………………………………	$______________
11. Utilities ………………………………………………	$______________
12. Auto (Gas, Repairs) …………………………………	$______________
13. Telephone ………………………………………………	$______________
14. Cable ………………………………………………	$______________
15. Entertainment………………………………………………	$______________
16. Clothing ………………………………………………	$______________
17. Child Care ………………………………………………	$______________
18. Child Support/Alimony …………………………………..	$______________
19. Medications ………………………………………………	$______________
20. Other ………………………………………………	$______________

Creditors

Please indicate all other monthly payments, e.g., bank payments, credit cards, other medical, etc.

	To Whom	Unpaid Balance	Monthly Payment
21. Rent/Mortgage	____________	$____________	$____________
Original Principal $____________			
22. Medical: Doctor	____________	$____________	$____________
23. Medical: Hospital	____________	$____________	$____________
24. Credit Card	____________	$____________	$____________
25. Credit Card	____________	$____________	$____________
26. Home Equity Loan	____________	$____________	$____________
27. Other	____________	$____________	$____________
28. Other	____________	$____________	$____________

Insurance		Annual Premium	Monthly Payment
29. Auto	____________	$____________	$____________
30. Life	____________	$____________	$____________
31. Health	____________	$____________	$____________
32. Other	____________	$____________	$____________

33. Total Monthly Expenses (add lines 10 through 32) $____________

Income Less Expenses (line 7 minus 33) $____________

Certification

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by Meeker Memorial Hospital and Clinic. I hereby grant permission to Meeker Memorial Hospital, its affiliates and representative to investigate the information contained herein, and to obtain a credit report.

Signature______________________________ Date______________