

Patient Account# \_\_\_\_\_

**MARY GREELEY MEDICAL CENTER FINANCIAL ASSESSMENT FORM**

**Entire Form Must Be Completed**

Patient/Guarantor Name \_\_\_\_\_

Patient Name (If different from guarantor) \_\_\_\_\_

**ASSETS**

\$ \_\_\_\_\_ Checking Account Balance  
\_\_\_\_\_ Financial Institution Name (Attach copy of last three monthly statements showing account balance)

\$ \_\_\_\_\_ Savings Account Balance  
\_\_\_\_\_ Financial Institution Name (Attach copy of last three monthly statements showing account balance)

\$ \_\_\_\_\_ Money Market \$ \_\_\_\_\_ IRAs \$ \_\_\_\_\_ Stocks/Bonds (cash value)

\$ \_\_\_\_\_ Other Assets – Describe: \_\_\_\_\_

\$ \_\_\_\_\_ Value of Boats, Trailers, Livestock, Farmland, Residential Property (NOT primary residence) Describe: \_\_\_\_\_

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**GROSS MONTHLY INCOME OF ALL MEMBERS OF HOUSEHOLD**

\$ \_\_\_\_\_ Wages  
\$ \_\_\_\_\_ Social Security Income  
\$ \_\_\_\_\_ Unemployment  
\$ \_\_\_\_\_ Workers Compensation  
\$ \_\_\_\_\_ Child Support/Alimony  
\$ \_\_\_\_\_ Public Assistance  
\$ \_\_\_\_\_ Food Stamps  
\$ \_\_\_\_\_ Disability Waiver Income  
\$ \_\_\_\_\_ Pension/Retirement  
\$ \_\_\_\_\_ Annuity/Dividends  
\$ \_\_\_\_\_ Interest  
\$ \_\_\_\_\_ Cash from Relatives  
\$ \_\_\_\_\_ Other – Please Describe

\_\_\_\_\_  
\_\_\_\_\_  
\$ \_\_\_\_\_ TOTAL INCOME

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**Applicant Information:**

**Spouse/Significant Other Information:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Soc.Sec.No.: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Employer Phone: \_\_\_\_\_  
Date of Hire: \_\_\_\_\_  
Hrs.Worked per Week: \_\_\_\_\_  
Med. Ins. Company: \_\_\_\_\_  
DHS Caseworker: \_\_\_\_\_  
Caseworker Phone: \_\_\_\_\_

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**Family Members (in household)**

**Birth Date**

**Relationship**

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**Please describe your personal situation and your reasons for requesting assistance:**

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**If your financial assistance application is showing no income at all please describe how you provide for your everyday living expenses such as housing, food, clothing, etc.**

\_\_\_\_\_  
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\_\_\_\_\_

You must return copies of the following documents with this application. **Any application without signature and the necessary documentation will be denied.**

**Needed Documentation**

*All applicant and/or spouse information required*

- \_\_\_\_\_ Proof of Income –last 3 paycheck stubs, or, letter from employer
- \_\_\_\_\_ 2009 Federal Tax Return
- \_\_\_\_\_ Last 3 statements for checking, savings, stocks, bonds, annuities, etc.
- \_\_\_\_\_ Financial Support Document from ISU if applicable
- \_\_\_\_\_ Anything else requested by Financial Counselor
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

***All above information will be shredded after application is processed so please do not send any original documents.***

I have read and understand the above conditions to receive financial assistance. I also understand that 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 Counselor  
Mary Greeley Medical Center  
P. O. Box 863  
Ames, IA 50010