

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: _____

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

08/11 90997349

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: _____

Family Members (in household)

Birth Date

Relationship

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

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.

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
- _____ 2011 W2’s
- _____ Last 3 statements for checking, savings, stocks, bonds, annuities, etc.
- _____ Financial Support Document from ISU if applicable
- _____ Anything else requested by Financial Counselor
- _____
- _____
- _____

Please do not send any original documents as they cannot be returned.

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