MOREHEAD MEMORIAL HOSPITAL

FINANCIAL DISCLOSURE

For help completing this application, please call 336-627-6195.

Mail date _____

PATIENT INFORMATION

Name: _____ SSN: _____

Address: _____ Birth date: ____/____/____

City, State, ZIP: _____ Employer: _____

County: _____ Work phone: (____) _____

Home phone: (____) _____ Work status: Full time ☐ Part time ☐

Avg. hrs worked/wk: _____

GUARANTOR (OR SPOUSE IF MARRIED)

Name: _____ SSN: _____ DOB: _____

Address: _____ Employer: _____

City, State, ZIP: _____ Occupation: _____

Relation to patient: _____ Work phone: (____) _____

Work status: Full time ☐ Part time ☐

Avg. hrs worked/wk: _____

FAMILY INFORMATION

(Family includes husband, wife, and any children [including stepchildren] that live in the home and are qualifying dependents for tax purposes.

Family members	Age	Relation to patient	Employed?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

MONTHLY GROSS FAMILY INCOME

Salary $ _____

Social Security $ _____

Retirement/pension $ _____

Unemployment $ _____

Guard/Reserve/Military pay $ _____

Interest/dividends $ _____

Disability/SSI $ _____

Work Comp benefits $ _____

Alimony/child support $ _____

TANF $ _____

Educational assistance $ _____

Net rental/lease cash flow $ _____

Other income/cash assistance

_____ $ _____

_____ $ _____

_____ $ _____

Total $ _____ **A**

If you have become unemployed within the last 90 days, please provide:
The name of your last employer and dates of employment:

_____

Give the name of your employer sponsored insurance carrier:

_____

Are you eligible for COBRA Benefits? ☐ Yes ☐ No

A X 12 = Annual income $ _____ **B**

MONTHLY FAMILY EXPENSES

Rent/Mortgage payment $ _____ **C**

C X 12 = Annual expenses $ _____

If you have no annual income please explain how basic expenses (e.g., housing, food, and transportation) are met.

_____

_____

_____

_____

Have you ever applied for financial assistance at Morehead Memorial Hospital? ☐ Yes ☐ No

All information you provide is treated confidentially and will be used only to determine whether financial assistance will be provided to you.

Continued on page 2. ALL sections must be completed.

FINANCIAL DISCLOSURE - page 2 Unit number _____ Patient name _____

1. Annual income (**B** from page 1) $ _____

ASSETS

To be completed bv MMH

Property	Mortgage/loan company	D Amount owed	E Market/tax value	E - D = Equity
2. Home	_____ Phone # _____	$ _____	$ _____	$ _____
3. Other real estate	Description _____	$ _____	$ _____	$ _____
	_____	$ _____	$ _____	$ _____
4. Owned vehicles (automobiles, boats, RVs, motorcycles, farm equip., etc.)	Make/model/yr _____	$ _____	$ _____	$ _____
	_____	$ _____	$ _____	$ _____
	_____	$ _____	$ _____	$ _____
			Total Property	$ _____ **E**
			E X 0.2 = *Eligible Property*	$ _____ **F**

Cash and Investments

	Bank name	Account #	Checking	Savings	Current balance
5. Bank accounts	_____	_____	☐	☐	$ _____
	_____	_____	☐	☐	$ _____
	_____	_____	☐	☐	$ _____

Cash on hand

☐ No bank → $ _____

Checklist:

- ☐ Complete ALL sections of the application.
- ☐ Sign and date the application.
- ☐ Proof of vehicle balance.
- ☐ Proof of home balance.

Attach copies of the following (if applicable):

- ☐ Most recent Federal tax return (including Schedule C if self-employed).
- ☐ Two (2) most recent pay stubs or other proof of income/cash benefits.
- ☐ Property valuation statements for property outside of Rockingham County.
- ☐ Two (2) most recent Bank statements.
- ☐ Driver's license.

- INCOMPLETE APPLICATIONS MAY BE DENIED -

I hereby certify that all information on my application for financial assistance, including information on the reverse side of this form, is correct and complete to the best of my knowledge, information given and my belief. I understand and agree that if Morehead Memorial Hospital learns that I have made false statements or misrepresented any information on this application for financial assistance, will make me ineligible for any financial assistance. I authorize the release of any information needed to verify the information provided and for billing and collections in compliance with applicable federal and state laws. Additional proof of income may be required before consideration is made.

Applicant signature _____ Date _____

Person supplying information (if different from applicant) _____ Relationship to applicant _____

Please return form and all supporting documentation (see page 2 for checklist) within 30 days to:

Morehead Memorial Hospital
Patient Accounting
117 E Kings Hwy.
Eden, NC 27288-5299