Program Applying For:

- □ Uninsured Financial Assistance (Free/Discounted Care)
- □ Catastrophic Discount

Meadville Medical Center Financial Assistance Program Application

NOTE: This application is for Meadville Medical Center Charges only (does not include Independent Physician Professional charges)

Please complete both sides of this form Return the signed form with all required documents to the address below.

Meadville Medical Center, CBO Mail Processing Center, 1643 Lewis Avenue, Suite 203,Billings, MT 59102

Date of Application: _____ Date Application Mailed: _____

1. PATIENT INFORMATION*: -PLEASE PRINT ALL INFORMATION-

Last Name	First Name	M.I.

*** If the Patient is a minor or full time student, please list parent(s)/guardian(s) as applicant and co-applicant**

2. APPLICANT (PATIENT/PARENT/GUARDIAN) INFORMATION:

Relationship to Patient:

□ Self □ Spouse □ Parent □ Other

Marital Status:

□ Single □ Married □ Divorced □ Separated

Last Name	First Name	M.I.	Social Security Number	Date of Birth

Street Address	City	State	Zip Code	Phone ( )

Current Employer	Street Address	Phone ( )	Position	Yrs Employd

Total Number of Dependents: (other than self and co-applicant)	Dependent Name	Date of Birth	Relationship

3. CO- APPLICANT (SPOUSE/PARENT/GUARDIAN) INFORMATION:

Relationship to Patient:

□ Spouse □ Parent □ Other

Last Name	First Name	M.I.	Social Security Number	Date of Birth

Street Address	City	State	Zip Code	Phone ( )

Current Employer	Street Address	Phone ( )	Position	Yrs Employd

Total Number of Dependents: (other than self and co-applicant)	Dependent Name	Date of Birth	Relationship

4. INCOME INFORMATION:

List all contributing gross income. Include gross wages, salaries, dividends, interest, social security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates, trusts and veteran stipends

Monthly Income Sources	Applicant	Co-Applicant	Combined **Monthly** Income
Gross Wages			
Worker's Compensation	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Pension	$	$	$
Other:	$	$	$
Other:	$	$	$
Other:	$	$	$
		Total Combined Monthly Income:	$ Add all income above

5. ASSETS:

Do not include the Patient's primary residence. Please list assets and approximate value.

Acceptable documentation includes banking statements from financial institutions or some other third party verifications of asset value (Checking, Savings, Money Market, CD's, 401K, IRA's, etc.)

Asset Name:	Approximate Value:
1)	$
2)	$
3)	$
4)	$

6. MEADVILLE MEDICAL CENTER SERVICES:

Please indicate your Inpatient Stays or Outpatient and Emergency Department visits in the last twelve months (calendar year if insured)

Account Number	Date(s) of Service	Patient Balances	Account Notes
		$	
		$	
		$	
		$	
		$	

7. ADDITIONAL INFORMATION/COMMENTS:

8. SIGNATURE:

By signing below I certify that all information is valid and complete.
I will immediately notify Meadville Medical Center if my financial circumstances change.

Applicant Signature	Date	Co-Applicant Signature	Date

Please submit the following information with your application:

- □ Federal Income Tax Return - *preferred* (or) 90 days of most recent paycheck stubs (or) other proof of income
- □ Driver's License/State-issued ID
- □ Recent Bank Statements (Checking and Savings)
- □ Other Resources (IRA's; 401K, etc.)
- □ Medicaid Denial Letter

If applicable, please submit the following:

- □ Social Security Award letter
- □ Financial Award Letter(s) for any student loans or grants
- □ Room and Board Statement (if no income)
- □ Unemployment Compensation Benefit Award Letter

Return completed form and supporting documents to:

Meadville Medical Center
CBO Mail Processing Center
1643 Lewis Avenue
Suite 203
Billings, MT 59102

If you have any questions or need additional assistance, please call us at 888-219-6117.