MetroSouth Medical Center
Financial Assistance Application

I have read the attached cover page and understand that all information will be reviewed for a decision based on me paying the application fee for processing.

Patient Name ________________________________ Type of Service _________________

Address ____________________________________ Phone (______) __________________

Account # __________________________________ Date of Service____________

Account Balance $ ___________________________

Does the Patient have other accounts that qualify for review under this application?

Account # _______________________ Balance $________________
Account # _______________________ Balance $________________
Account # _______________________ Balance $________________

Employer Information _______________________________________
(If line blank , last time worked _____________.)

☐ FT ☐ PT

Income

☐ Employer Group ☐ Private Business Owner ☐ SSI Disability

☐ Pension ☐ Trust Fund ☐ Workers Comp

☐ Unemployment Security ☐ Child Support

Number of Dependents in household

Name of Dependents	Date of Birth	Social Security Number

House Hold Expenses

Provide your monthly cost for expenses

Rent/ Mortgage $ ____________ Phone $ __________ Medications $_______

Gas / Electric $____________ Food $ __________ Water Bill $_________

Travel/Car or Bus $_____________ Child Care$________ Property Tax $ _______

Banking Information

Banking Institution __________________________________

Checking $_________ Savings $ ___________

Have you applied for any assistance through any government agency and been denied under their guidelines? ☐ Yes ☐ No

If yes specify agency below.

☐ Medicaid ☐ Social Security Disability ☐ Kid Care ☐ Crime Victims

I understand that completion of the financial assistance application is not a guarantee that I will meet the required guidelines to justify charity care under the program. I hereby attest that all information provided in this application is true based on my income and asset. My signature is consent to a review of my income background by MetroSouth account representative to validate my status for assistance under their program here at MetroSouth Medical Center.

Patient Signature ____________________________________ Date ________

Account Rep _______________________________________ Date ________

Final Decision

Director Signature __________________________________ Date _________
(All accounts $4999.99 and below)

CFO Signature _____________________________________ Date _________
(All accounts $5000.00 and over)