APPLICATION FOR PCMH - FAMILY ASSISTANCE PLAN

Patient Name	Date of Birth	Phone No.	Marital Status S M W D	Social Security Number
Responsible Party Name	Date of Birth	Phone No.	Marital Status S M W D	Social Security Number
Spouse Name	Date of Birth	Phone No.		Social Security Number

Address	**IMPORTANT:** Complete the application entirely including the signed bank confirmation letter, most current tax return information and last three check stubs.
Email Address:	

How long have you lived in Pike County, Missouri? **Please list years:**

Employer (name & address)	Spouse Employer (name & address)
Phone number	Phone number
Position	Position
Length of employment	Length of employment

Health Insurance Plan:
Health Insurance ID #:
Group #:

Please list all dependents (Only those that qualify on your 1040 tax return):

Name:		Date of Birth:	
Name:		Date of Birth:	
Name:		Date of Birth:	
Name:		Date of Birth:	
Name:		Date of Birth:	

Gross Monthly Income for the Household				
	Responsible Party	Spouse	**Monthly Household Expenses**	
Wages			Housing	
Social Security			Food	
Pension			Clothing	
Rental Income			Utilities	
Alimony			Taxes	
Child Support			Insurance	
Gov't Assist.			Child Care	
Unemployment			Transportation	
Other			Other	
Total			**Total**	

List any vehicles owned by household members			Do you own your home?	
Automobile	Model	Year	Home Value	$
			Do you have life insurance?	
			Loan Value	$

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List Creditor Name and Addresses	Account	Balance	Monthly Payment
1.			
2.			
3.			
4.			
5.			
6.			

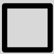
*If additional space is needed, please attach separate sheet.

Please use the following space to list all assets (i.e. houses, land, equipment, etc.)

Item	Current Value	Rental Income	Other Income	Comments
	$	$		
	$	$		
	$	$		

*If additional space is needed, please attach separate sheet.

Comments below:



Please check box if you would like to use this application to also apply for the PCMH Clinics Sliding Fee Application

I/We certify that the statements and financial information contained in this application are true and correct as of this date. I/We authorize Pike County Memorial Hospital to verify any and all information submitted.

Responsible Party ________ Date ________ Spouse ________ Date ________

Verification Checklist (attach copies):

Have you applied for Medicaid? If you have been denied, a written denial of coverage will be required.

Income: Most recent tax return (Federal 1040) and three most recent pay stubs.

Insurance: Insurance card(s)

Identification/Address: Driver's license, birth certificate, employment ID, Social Security card, other.

Signed Bank Confirmation Letter

Return to:
Pike County Memorial Hospital
ATTN: Business Office
2305 Georgia St.
Louisiana, MO 63353

For Assistance call 573-754-5531
Ext 118