Madelia HEALTH

CHARITY CARE APPLICATION

121 Drew Avenue SE, Madelia, MN 56062

Phone: 507-642-3255

Name: _____ **Birthdate**: _____

(Patient)

Name:_____ **Birthdate**:_____

(Guarantor/Responsible Party)

Address:_____**City**:_____**State**:_____**Zip**:_____

(Guarantor/Responsible Party)

Telephone:_____ **Number of Dependent Children**:_____ **Number of Members in Household:**_____

MONTHLY INCOME

Patients Employer: _____
Address:_____
City:_____
How long: _____Gross Wages $_____
Self-employed: Y or N **Monthly Income:** _____
Unemployed _____ **How long** ?_____
Unemployment Comp._____$_____
Social Security _____$_____
Worker's Comp._____$_____
Child Support/Alimony_____$_____
Public Assistance/Housing/Food Stamps_____$_____
Other Income_____$_____
Source:_____

TOTAL $_____

Spouse/Parent Employer: _____
Address:_____
City:_____
How long: _____**Gross Wages** $_____
Self-employed: Y or N **Monthly Income:** _____
Unemployed _____ **How long**? _____
Unemployment Comp. _____$_____
Social Security _____$_____
Worker's Comp. _____$_____
Child Support/Alimony_____$_____
Public Assistance/Housing/Food Stamps _____$_____
Other Income_____$_____
Source:_____

TOTAL $_____

The following documents must be provided for patient and guarantor:

- Copy of your previous Federal Tax Return
- Copy of your two most recent pay stubs for each working adult in your household

OR

- An 'Employment Verification Response' form from the county of residence

The above information will be kept confidential and will only be used in the determination of discount eligibility. The undersigned certifies that the information has been carefully read and is true and correct to the best knowledge of the undersigned.

Signature_____Date_____

For Office Use Only Approved Denied

Patient Account#:_____Account Balance: $_____Amount of Discount: %_____