Civista Medical Center—Financial Assistance Application

TELL US ABOUT YOURSELF

Applicants Name _____ Date of Birth _____
First Middle Last

Home Address _____
(include Street Address and P.O. Box)

_____
City State Zip Code

Home Number _____ Cell Phone Number _____

Social Security Number _____ US Citizen **YES** **NO**
Permanent Resident **YES** **NO**

Martial Status **Single** **Married** **Widow** **Divorced**

Spouse's Name _____ Social Security Number _____

HOUSEHOLD MEMBERS (List Dependents Name, Age and Relationship to Applicant)

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

MEDICAL ASSISTANCE

Do you receive any type of state or county assistance? **YES** **NO**

Have you applied for Medical Assistance? **YES** **NO**
If yes, what was the date you applied? _____
If yes, what was the determination? DENIED_____ APPROVED _____SPENDDOWN _____
Medical Assistance Number _____

NOTE: Attach copy of Approval or Denial letter from Medical Assistance

ABOUT YOUR INCOME

Employer Name _____ Phone Number _____

Work Address _____
(include Street Address and PO Box) City State Zip Code

Spouse Employer Name _____ Phone Number _____

Work Address _____
(include Street Address and PO Box) City State Zip Code

FAMILY INCOME

MONTHLY AMOUNT		MONTHLY AMOUNT	
Employment (before taxes)	$_____	Spouse's Employment (before taxes)	$_____
Disability Benefits	$_____	Veteran's Benefits	$_____
Retirement/ Pension Benefits	$_____	Alimony	$_____
Social Security Benefits	$_____	Strike Benefits	$_____
Public Assistance Benefits	$_____	Military Allotment	$_____
Unemployment Benefits	$_____	Rental Property Income	$_____
Farm or Self Employment	$_____	Other Income Source	$_____

Total Monthly Income $ _____

LIQUID ASSETS

CURRENT BALANCE

Checking Account	$_____
Savings Accounts	$_____
Stocks, Bonds, CD, or Money Market	$_____
Other Accounts	$_____
TOTAL	**$ _____**

OTHER ASSETS (If you have any of the following items, please list the type and approximate value.)

Home	Loan Balance $_____	Approximate value $_____
Automobile	Make/Model_____ Year _____	Approximate value $_____
Automobile	Make/Model_____ Year _____	Approximate value $_____
Boat/ATV	Make/Model_____ Year _____	Approximate value $_____
Other Property (please specify)	_____	Approximate value $_____
	TOTAL	**$ _____**

MONTHLY EXPENSES

		MONTHLY AMOUNT
Rent _____ Mortgage _____ (please check one)		$_____
Utilities:	Telephone $_____	
	Electric/Gas $_____	
	Cable $_____	
	Water $_____	
	Trash $_____	Total Utilities $_____
Car Payment(s)		$_____
Credit Card(s)	_____ (Name) _____ (Name) _____ (Name)	$_____
Car Insurance		$_____
Health Insurance		$_____
Other Medical Expenses		$_____
Other Expenses		$_____
	TOTAL	**$_____**

I understand that the information I have submitted is subject to verification by Civista Medical Center, Inc., and by signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant's Signature Date Spouse's Signature Date