MONTGOMERY GENERAL HOSPITAL

ASSISTANCE PROGRAM

Enclosed you will find a Patient Financial Statement pertaining to the account with Montgomery General Hospital. In order to process your financial statement quickly and efficiently, please provide copies of the following as they pertain to you:

1. Copies of last month's:
   a. Paycheck Stubs
   b. Social Security Check
   c. Unemployment or Worker's Compensation Check
   d. Child Support Verification
   e. Retirement or Pension Check
   f. Bank Statement
2. A copy of last year's tax returns

- If there is no income and/or food and shelter is being provided by somebody else, please complete the attached letter, which much be signed by the patient and notarized and returned with the application.
- Please complete all fields on the application. If the fields do not pertain to you, please mark N/A.
- When we receive the completed form, your account will be reviewed for possible assistance. If you have any questions please feel free to contact us at 304-442-1247 or 304-442-7405.
- Please return your application to:

Montgomery General Hospital

P.O. Box 270

Montgomery, WV 25136

MONTGOMERY GENERAL HOSPITAL
CHARITY APPLICATION

Account No. _____ Date of Request: _____

I hereby request that Montgomery General Hospital make a written determination of my eligibility for Charity services at its facility. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by Montgomery General Hospital. I also understand that if the information, which I submit, is determined to be false, such a determination will result in a denial of Charity services, and that I will be liable for charges of services provided.

Patient Name: _____ Phone No. _____

Guarantor: _____ Relationship: _____

Address: _____

Occupation: _____(yr.)_____ Employer: _____

Family Size: _____ Name Relationship

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Expected date(s) of services: _____

PROOF OF INCOME
FOR LAST 12 MONTHS

List income for family from:

1. Wages	_____	Copy of prior year W2
	_____	Copy of last two months check stubs
2. Savings Account	_____	Name of Bank _____
3. Checking Account	_____	Name of Bank _____
4. Social Security	_____	Copy of Social Security Check
5. Unemployment	_____	Copy of Unemployment Check
6. Worker's Compensation	_____	Copy of Work's Comp Check
7. Pensions	_____	Copy of Check
8. Alimony/Child Support	_____	Copy of Check
9. Public Assistance	_____	Copy of Check/Food Stamp Voucher
10. Income from dividends, interest	_____	Copy of Bank Statement
11. Farm or Self-employment	_____	Copy of Quarterly Taxes
12. Rent/Mortgage	_____	Attach Proof
13. Other	_____	Attach Proof

I affirm that the following information is true and correct to the best of my knowledge.

Date: _____ Signature: _____

No Income Statement

I, _____ do hereby attest that I/we have absolutely
(applicant name)

no income from any source.

Food and shelter are being provided to me/us by: _____.
(name of other party)

Applicant signature: _____ Date: _____
Other Party signature: _____ Date: _____

Taken, subscribed, and sworn to before me, this ___day of _____, 20___.
My commission expires _____.

_____
Notary Public

Eligibility Determination

Applicant Name: _____

Account Number(s): _____

Based on the information supplied by the Applicant or on behalf of the Applicant, the following determination has been made concerning the Charity Application dated _____:

1. ____ Your request for Charity has been approved for services rendered.
   ____ Other _____

This application is approved for the period beginning

_____

and ending

_____

2. ____ Your request for Charity has been denied because:
   ____Your income exceeds the criteria specified
   ____ Other _____

The following documents were provided to verify income and family composition:

____Pay Stubs ____Income Tax Returns ____Other

Determination made by: _____

Date: _____