MCH
MONROE COUNTY
HOSPITAL
2016 SOUTH ALABAMA AVENUE
POST OFFICE BOX 886
MONROEVILLE, ALABAMA 36461
PHONE (251) 575-3111

Thank you for your interest in the Monroe County Hospital Financial Assistance Program. Please return the following documents along with the completed application. Incomplete applications will not be processed.

One of the following proofs of income must be submitted:

- IRS Form W-2 from the previous year AND your two most recent pay stub
- Previous year's income tax return AND your two most recent pay stub
- Written verification of earnings from your employer
- Verification from the Unemployment Office or DCF that shows your income status for the past 12 months OR notice of approved disability (which lists monthly benefit).

Provide documentation of any child/spousal support or government benefits you or members of your household receive (SNAP, WIC, etc).

Please return the completed application along with all required documents to Monroe County Hospital or mail to:

Monroe County Hospital
Attn: Financial Counseling
PO Box 886
Monroeville, AL 36461

You will be notified in writing regarding the status of your completed application. If you have any questions regarding this application, a Financial Counselor will be happy to speak with you about it. Our financial counselors are available Monday – Friday, 7:30 am – 4:30 pm and can be reached via telephone at (251) 743-7376 or (251) 743-7565.

We care for our community and look forward to serving you in the future.

Monroe County Hospital Financial Assistance Application

Patient Name _____ SS# _____
Last First MI

Date of Birth _____ Home Phone# _____ Cell Phone# _____

Address _____
Street Name/Apt# City State Zip

Employer _____
Name of Employer Address Work Phone#

Income $_____ $_____ $_____
Hourly Wage Monthly Wage Gross Yearly Wage

Spouse/Parent _____ SS# _____
Last First MI

Date of Birth _____ Home Phone# _____ Cell Phone# _____

Address _____
Street Name/Apt# City State Zip

Employer _____
Name of Employer Address Work Phone#

Income $_____ $_____ $_____
Hourly Wage Monthly Wage Gross Yearly Wage

(Complete only is different from Patient or Spouse/Parent)

Guarantor/
Responsible Party _____ SS# _____
Last First MI

Date of Birth _____ Home Phone# _____ Cell Phone# _____

Address _____
Street Name/Apt# City State Zip

Employer _____
Name of Employer Address Work Phone#

Income $_____ $_____ $_____
Hourly Wage Monthly Wage Gross Yearly Wage

Name and Age of All Members Living in the Household

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

I certify that the above information is true to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, insurance, etc.) which may be available for payment for my Monroe County Hospital bill. I will also take any action necessary to obtain such assistance and will assign or pay to Monroe County Hospital the amount recovered for home medical equipment charges.

I understand that this application is made so that Monroe County Hospital can judge my eligibility for uncompensated services, based on the established criteria on file. If any information I have given proves to be untrue, I understand Monroe County Hospital may reevaluate my financial status and take whatever action becomes appropriate.

Patient _____ Date _____

Guarantor _____ Date _____

Hospital Representative _____ Date _____

Financial Statement

	Creditor	Monthly Payment	Balance Due	Comments
Rent/Mortgage				
Automobile				
Gas/Electric				
Water				
Telephone				
Child Care				
Insurance				
Furniture				
Appliances				
Credit Card				
Credit Card				
Loan				
Medical Bill				
Pharmacy Bill				
Doctor Bill				
Misc/Other				

Property
Yearly Taxes $_____

Financial Institutions
Name of Bank or Credit Union _____

Savings Account $_____ Checking Account $_____ Retirement Account $_____

Other Assets or Income (CDs, Stocks, Bonds, etc.) _____

Do you or a member of your household receive Food Stamps or Government Aid? __ Yes __ No If so, how much? $_____

Have you applied for Medicaid? __ Yes __ No Are you currently receiving Medicaid? __ Yes __ No

Have you applied for Social Security? __ Yes __ No Have you been denied for Social Security? __ Yes __ No

Are you currently appealing a Social Security denial? __ Yes __ No

The information submitted in this application is both complete and correct to the best of my knowledge. I understand that the information is subject to verification by Monroe County Hospital

_____ _____

Patient Date Guarantor/Spouse/Parent Date