MCH
MONROE COUNTY HOSPITAL

2016 South Alabama Avenue
Post Office Box 886
Monroeville, AL 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 stubs
- Previous year's income tax turn **AND** your two most recent pay stubs
- 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 benefits).

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**
**P.O. 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, our Financial Counselor will be happy to speak with you about it. Our financial counselor is available Monday-Friday, 8:00 am - 4:00 pm and can be reached via telephone at (251) 743-7376.

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

**APPLICATION FOR FINANCIAL ASSISTANCE**
**PATIENT INFORMATION:**

Patient Name: _____SSN: _____
Date of Birth: _____ Employer: _____
Address: _____ City: _____
State/Zip: _____
Home Phone #: _____Cell Phone #: _____
Marital Status: Single Married Divorced Widow

**SPOUSE/GUARANTOR INFORMATION (if different from above)**

Name: _____ Relationship: _____
Address: _____ City: _____
State/Zip: _____
Date of Birth: _____SSN _____
Employer: _____
Home Phone #: _____ Cell Phone#: _____
Marital Status: Single Married Divorced Widow

**HOUSEHOLD INFORMATION**

Number in Household: _____, please list below (use separate sheet if necessary):
NAME: _____ AGE: _____
RELATIONSHIP: _____
NAME: _____ AGE: _____
RELATIONSHIP: _____
NAME: _____ AGE: _____
RELATIONSHIP: _____
NAME: _____ AGE: _____
RELATIONSHIP: _____
NAME: _____ AGE: _____
RELATIONSHIP: _____
NAME: _____ AGE: _____
RELATIONSHIP: _____
NAME: _____ AGE: _____
RELATIONSHIP: _____

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**TOTAL HOUSEHOLD INCOME**

Last 12 Months _____ Last 3 Months_____
Yearly Gross Household Income: _____

**SOURCE OF ALL HOUSEHOLD INCOME:**

Employment: _____ Unemployment: _____
Child Support: _____
SSl/SSD: _____
Other: (please specify): _____

- I certify that the above information is true and accurate to the best of my knowledge. Furthermore, I will complete applications for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available to pay for my hospital charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.
- I understand that this application is made so that the hospital can judge my eligibility for financial assistance. MCH Hospital reserves the right to verify all given information with credit bureaus and any other persons or creditors they see fit. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate.

**Applicant's Signature: _____Date: _____**

DO NOT WRITE BELOW THIS LINE: FOR OFFICE USE ONLY
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**ELIGIBILITY DETERMINATION**
Patient Qualifies: Yes _____ No _____
The applicant 's request for financial assistance has been denied for the following reasons:

Date of Determination of Eligibility: _____
Date Applicant Notified: _____

Signature of Hospital Representative:

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**MCH Health Financial Assistant Program**

Services not covered by the MCH Health FAP:

• **Procedures considered as elective**
o Cosmetic surgery
o Breast implants
o Breast Reduction
o Infertility treatment

• Transportation and Lodging,
• Food (other than that provided as an inpatient),
• Durable Medical Equipment
• Prescriptions (other than those provided as an inpatient, or during treatment).
• Home Health Care
• Hospice Care
• Physician Services (unless provided by MCH Practices/hospitalization and listed in the USA FAP
Addendum – Practices that provide emergency or other medically necessary care in the hospital facilities
• Expenses for the patient's relatives
• Teeth extractions and Dentures
• Addiction Recovery Service

This is a non-exhaustive list of services and is used to indicate that not all expenses can be expected to be covered by the FAP.

MCH Health has limited resources and cannot cover all expenses at free or reduced charges.

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**Verification of Income**

• If you are currently employed, please provide verification of gross income for the last month. Verification can be a check stub or a letter from your employer on company letterhead.
• If you are self-employed, please provide a copy of your prior year's Tax Return, including all forms.
• If you are unemployed and drawing unemployment benefits, please provide verification of the amount you receive. Verification can be your notice of approval.
• If you are unemployed and have no income, please provide verification of your circumstances. Verification can be a statement from your physician, your church pastor, or attorney.
• If you are receiving Social Security Benefits, SSI, Social Security Disability, veteran's benefits a Military, Government or Private Pension, please provide verification of that income. Verification can be a copy of your most recent check/stub or deposit verification or a letter from the government or pension authority showing the amount you are receiving. If you have minor children or other members of your household receiving monthly payments, please show proof of those amounts.
• If you are collecting a retirement check, pension, annuity, short/long-term disability or worker's compensation, please provide verification of that income.
Verification can be your most recent check/stub or a letter from the income source.
• If you are collecting governmental assistance, such as rent assistance in a H.U.D. Property, Food Stamps, Medicaid, Alabama All Kids, Alabama Family Assistance, SNAP, WIC, Section 8 Housing, live in an AHEPA apartment, then you will have already had your income and assets verified and as such can use your governmental assistance as verification of income. A copy of your documentation of assistance can be provided as proof of income.
• If you receive child support or alimony or receive assistance from your child's other parents (not living in your household), please provide verification of that income. Verification can be your child support order or divorce decree.
• If you are separated or going through a divorce, please provide legal proof of your separation or a letter from your lawyer.
• If your expenses exceed your income, please provide verification of how your monthly expenses are being satisfied. Verification can be letters of financial support from your family, friends, church, or other organizations. Verification can be letters of financial support from your family, friends, church, or other organizations. If you are using credit cards, cash advances or loans to satisfy your monthly expenses, please provide copies of the most recent statement of those items.