# MEMORIAL MEDICAL CENTER

## FINANCIAL ASSISTANCE APPLICATION FORM

MMC HOSPITAL: _____ CLINIC: _____ MED REC# _____

ACCOUNT #: _____ DATE OF SERVICE: _____

PATIENT NAME _____ SS#: _____

GUARANTOR NAME _____ REL TO PT _____

ADDRESS: _____ PHONE # _____

EMPLOYER _____

RESIDENT OF DONA ANA YES _____ NO _____ IF YES, HOW LONG? _____

HAVE YOU APPLIED FOR COMMUNITY BENEFIT PROGRAM YES___ NO ____ IF YES, WHEN: _____

DO YOU HAVE MEDICAL INSURANCE YES_____ NO_____ COMMENTS _____

HOUSEHOLD MEMBERS

| NAME | RELATIONSHIP | | DOB | SS# |
|---|---|---|---|---|
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TOTAL NUMBER OF HOUSEHOLD MEMBERS _____

| HOUSEHOLD INCOME | SOURCE OF INCOME | MONTHLY AMOUNT BEFORE TAXES | VERIFICATION |
|---|---|---|---|
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TO INCLUDE EARNED INCOME, UNEMPLOYMENT BENEFITS, DISABILITY, CHILD SUPPORT,SOCIAL SECURITY,PUBLIC ASSISTANCE, EDUCATIONAL ASSISTANCE, FOOD STAMPS, EXTENDED FAMILY ASSISTANCE OR OTHER

TOTAL HH INCOME: _____ CB DISCOUNT _____

I HEREBY CERIFY THE ABOVE INFORMATION TO BE CORRECT AND I AM RESPONSIBLE FOR NOTIFYING MMC OF ANY CHANGES IN RESIDENTIAL AND/OR INCOME STATUS

SIGNATURE _____ DATE _____

WITNESS/NAME/TITLE _____ DATE _____

MANAGER/SUPERVISOR _____ DATE _____

CFO _____ DATE _____

**THIS DISCOUNT DOES NOT APPLY TO NEWBORN DELIVERY SERVICES

CB APPLICATION REV 012026