



IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help St. Margaret's Health determine if you can receive free or discounted services or other public programs that can help you pay for your healthcare. Please submit this completed application to St. Margaret's Health.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE CARE.

However, a Social Security Number is required for some public programs, including Medicaid.

Providing a Social Security Number is not required but will help St. Margaret's Health determine whether you may qualify for any public programs.

Please complete this form and submit it to St. Margaret's Health in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist St. Margaret's Health in determining whether the patient is eligible for financial assistance.

Guarantor (Responsible party/person)

Name: _____

Birthdate: _____

Social Security Number: _____

Street Address: _____

City/State/Zip: _____

Telephone / Cell Phone: _____

Email: _____

Marital Status: _____

Income

Employer:

Name: _____

City/State/Zip: _____

How long employed: _____ Gross Wages: _____
(mo/years) (weekly, bi-weekly, monthly)

Additional Employer:

Name: _____

City/State/Zip: _____

How long employed: _____ Gross Wages: _____
(mo/years) (weekly, bi-weekly, monthly)

Other Income You Receive (Mo. Amt.)

Social Security/Disability Amount \$ _____

Pension Amount/ Veterans Benefits \$ _____

Unemployment or Work Comp Amount..... \$ _____

Alimony Amount/ Child Support \$ _____

Other Income Amount (Housing allowance, food stamps, interest income, etc.)..... \$ _____

Explain: _____

Spouse

Name: _____

Birthdate: _____

Social Security Number: _____

Street Address: _____

City/State/Zip: _____

Telephone / Cell Phone: _____

Email: _____

Marital Status: _____

Income

Employer:

Name: _____

City/State/Zip: _____

How long employed: _____ Gross Wages: _____
(mo/years) (weekly, bi-weekly, monthly)

Additional Employer:

Name: _____

City/State/Zip: _____

How long employed: _____ Gross Wages: _____
(mo/years) (weekly, bi-weekly, monthly)

Other Income You Receive (Mo. Amt.)

Social Security/Disability Amount \$ _____

Pension Amount/ Veterans Benefits \$ _____

Unemployment or Work Comp Amount..... \$ _____

Alimony Amount/ Child Support \$ _____

Other Income Amount (Housing allowance, food stamps, interest income, etc.) \$ _____

Explain: _____

