For HOSPITAL USE ONLY: *do not write here* ***Expires one year from approval date***

Medical Record number: #	**Gross Monthly Income: $**	**ADMINISTRATOR Approved / rate**
Number in household:	**MGGH Balance: $**	**Approved disc: 0% 25% 50% 75% 100%**
		Administrator Initial / date

MT GRANT GENERAL HOSPITAL

Mailing Address
PO Box 1510
Hawthorne, NV 89415

APPLICATION for FINANCIAL ASSISTANCE
APPLICATION/UPDATE/CHANGE FORM

775-945-2461

Street Address
200 South A Street
Hawthorne, NV 89415

This form may be duplicated. Print legibly or type information requested on the form in its entirety. If any of the information on this form changes, submit a revised form to the department. ***Attach additional page(s) as necessary*.**

Legal Name of Applicant: _____ **Phone:**

Please list any aliases/previous names: _____ Cell :

Date of Birth: **Age:**

Current Address: **(**street**)** _____ **PO Box**:

(city**)** (state) (zip code)

Marital Status (circle one): Single Married Divorced Separated Widow(er)

Social Security Number: **Driver's License # / State:**

Reason for submission of forms (circle one): New Applicant Name change Employment Status Address Change Additional Family Member Update requested

Please list all persons living within the Applicant's household (self) : *** use additional sheets as needed ***	**Date of birth:**	**SSN:**	**Do they have a source of income and amount (if employed, hours per week worked)attach proof of income**
			Yes No $
			Yes No $
			Yes No $
			Yes No $

Applicant/Guarantor Employer Name: Address: Phone:

Position / Length of Employment: Salary / Hours Worked per Week: $

*** Spouse / "Significant Other" Employer Name:** Address: Phone:

Position / Length of Employment: Salary / Hours Worked per Week: $

***For the purposes of this application spouse may refer to "significant other or any other person residing in the household ***
PROOF OF INCOME IS REQUIRED: (CURRENT W2/PAY STUBS, RECENT TAXES FILED, 1099 FORMS* AND TWO BANK STATEMENTS)
Applications not including this information will be delayed; those not responding to requests will be destroyed after 15 business days.

***For participants: must include previous, current and pending years (if applicable – near end of year.) MUST BE SUBMITTED/UPDATED ANNUALLY**

APPLICATION/UPDATE/CHANGE FORM
Page two

Nearest friend or relative NOT LIVING in your household	Name:	Relationship:
Address:		Phone number:

Insurance Information: ** use additional sheets as needed **	**Is anyone in household eligible or receiving:**	**Medicare: (circle)** YES NO	**Medicaid: (circle)** YES NO
INSURED'S NAME:	**Name of Insurance/Name of policy holder**	**Please circle one:**	**Insurance ID #**
		Primary Secondary	
		Primary **Secondary**	
		Primary Secondary	
		Primary Secondary	
		Primary Secondary	

Unearned Income:

Source:	Receiving:		Applied for:		For who:	Claim number:	Amount per month:
FOOD STAMPS	Yes	No	Yes	No			$
WIC	Yes	No	Yes	No			$
MEDICAL WELFARE MEDICAID	Yes	No	Yes	No			$
CHILD SUPPORT	Yes	No	Yes	No			$
ALIMONY	Yes	No	Yes	No			$
UNEMPLOYMENT	Yes	No	Yes	No			$
SOCIAL SECURITY	Yes	No	Yes	No			$
SUPPLEMENTAL SSI	Yes	No	Yes	No			$
VETERAN'S BENEFITS	Yes	No	Yes	No			$
DISABILITY	Yes	No	Yes	No			$
RETIREMENT	Yes	No	Yes	No			$
ANY OTHER INCOME (TYPE)	Yes	No	Yes	No			$

Resources:

Type:	(circle)		Name of Financial Organization:	Account VERIFIED -MONTH	Balance:
Checking Account	Yes	No			$
Savings Account	Yes	No			$
Credit Union Share	Yes	No			
Trust Account	Yes	No			
Savings Bonds	Yes	No			
Stocks/Bonds	Yes	No			

***** documents must be submitted to support information *****

*****Applicants with NO income source MUST also include a letter from the party who is providing living expenses *****

APPLICATION/UPDATE/CHANGE FORM

Type:	Monthly Cost:	Type:	Monthly Cost:
Water/Garbage/Sewage	$_____	**Electric Power**	$_____
Telephone	$_____	**Cell Phone**	$_____
Gas/Propane	$_____	**Cable TV/Satellite**	$_____
Rent/Mortgage Payment	$_____	**Groceries (estimated)**	$_____
Property tax if no mortgage	$_____	**Other** _____	**Other** $_____

CREDIT / CHARGE CARD:

Company Name	Balance Owing	Monthly Payment
	$	
	$	
	$	

Outstanding Loans:

Financial Institution	Balance Owing	Monthly Payment
	$	$ 245.35
	$	$
	$	$
	$	$

Are there any loans secured by collateral? (circle): Yes** No

**** If YES, by what collateral:** _____

Please submit copies of all household and medical bills
other than Mt Grant General Hospital or Mt Grant Medical Clinic*

List health care providers *other than Mt Grant General Hospital / Clinic:*	City and State:	Balance Owed:
		$
		$
		$

I authorize Mt Grant General Hospital to verify all information given on this application including but not limited to bank account information and credit references. The information provided is true to the best of my knowledge and any false information will be grounds for denial of the medical relief applied. I agree to make all co-payments at time of service. (Relief will not be applied until payment is made)

X _____ _____

Applicant Signature **Date**

For hospital use only – *SCAN AT TERM OR UPDATE*	Date received:	Received By:	**Completed Application:**
	Additional Information:	Notice Mail Date:	
	STATUS LETTER SENT: YES NO	1 YR RENEWAL SENT: YES NO	RENEWAL RCVD: YES NO

Potential updates every 6 months or when notified changes occur