MATAGORDA REGIONAL
MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

Patient Name		Account Number			
Guarantor Name		Birthdate		Age	
Address		Telephone			
Marital Status	Single	Married	Divorced	Widowed	Separated
Patient Social Security Number		Spouse Social Security Number			

County in which you reside in:

I am responsible for the support of the following:

Name	Birthdate	Relationship

Health Insurance / Medicare / Medicaid Information: (Circle One)

Group / Subscriber Number		Policy Owner	

Income: (Monthly)

Social Security	$	Unemployment Compensation	$
Veterans Pension	$	Workers Compensation	$
Railroad Retirement	$	Union Benefits	$
Employment	$	Child Support / Alimony	$
Dividends / Interest	$	Public Assistance, Food Stamps, Aid for Dependent Children	$
Rental Income	$	Other (Specify)	$
Retirement Income	$		$

Employment:

Name of Person Employed	Employer	Gross Pay		
		$	Weekly	Monthly
		$	Weekly	Monthly
		$	Weekly	Monthly

Deductions from Pay:

Federal / State Tax	Social Security	Union	Insurance	Pension	Other
$	$	$	$	$	$
$	$	$	$	$	$
$	$	$	$	$	$

I / We Own the Following:

Cash on Hand / Money in the Bank (Specify Bank)	$
Stocks / Bonds / Securities (Cash Value)	$

Real Estate	$
Other Real Estate (Location)	$

Monthly Expenses:

Automobiles	Car A	Car B	Car C
Year			
Make			
Model			
Balance Owed	$	$	$

Rent / Mortgage	$	Utilities	$	Transportation	$
Real Estate Tax	$	Food	$	Other (Specify)	$

Insurance (Specify Company)	$	Weekly	Monthly

Medical (Specify Hospital or Doctors Name)		$	Weekly	Monthly
Total Medical Bills Owed	$			

Installment Notes (Specify Creditor)	$	Weekly	Monthly

Other Debts (Specify Person or Entity Owed)	$

Comments:

I represent that the above information is true and correct to the best of my knowledge.

Signature: ____________________ **Date:** ____________