ASHLEY COUNTY MEDICAL CENTER
APPLICATION FOR UNCOMPENSATED CARE

1. Patient's Name_____ SS#_____ DOB_____
   Address_____ City_____ State_____ Zip_____
   Home telephone number_____ Cell_____

2. Household Members: (including yourself and/or patient)

Name	Age	Employer/School	Birth date

3. Income: List gross income of total household for the categories below. Please attach a copy of a recent pay stub, tax return, social security or disability statement, or other documentation of income::

	Last 3 months	Present
Wages		
Farm or Self-employment		
State Assistance		
Social Security		
Unemployment		
Alimony		
Child Support		
Military Fam Allotments		
Pension		
Other		

(**If there is NO income at all, please explain how you pay your monthly bills.)**

4. Monthly Bills (Please attach documentation of such as a copy of a payment coupon or a monthly statement):
   a. Mortgage/Rent _____
   b. Car Payment _____
   c. Credit Cards _____
   d. Other _____

5. List all checking and savings accounts, stocks, bonds, cash on hand, etc., for all household members_____
   _____

6. Does anyone in your household own any real estate (house, land, buildings, etc.)? YES_____ NO_____
   If yes, please supply information about the value of the property, any amount owed, and how the property is used._____
   _____

7. Do you rent?_____ Landlord_____ Phone #_____

8. Have you applied for Medicaid?_____ If denied, why?_____

My signature below signifies that the information I have provided on this application is true and accurate. I understand that falsification of information will invalidate this application. I authorize ACMC to make all inquiries as it deems necessary to verify the accuracy of the statements made herein.

_____ _____

Signature Date

06/20/2017