Initial Financial Assistance Request Form

The purpose of this form is to determine probable eligibility for financial assistance.

APPLICANT INFORMATION:

Patient Legal Name: ___ _____ MH#: __ _____

Address:

Street: _____

City:_____ Zip Code:_____

County:_____ State:_____

Telephone: _____ Email: _____

Name and contact information of person to be contacted on matters involving this application, if not given by patient

First Name: _____Middle Name: _____

Last Name: _____

Telephone Number: _ _____ Fax Number: _____

Form Completed by: _____ Date: _____

Relationship to Patient/Role:__ _____ Email: _____

Insurance Information: ____ _____

Medicaid Application Submitted? Yes No Status: approved_____ pending_____ denied _____

Current MH Status: Prospect __ ___ Enrolled/Active __ ____

Total Household Income: ___ _____

Total Number of Members in Household _____

Ages of Household Members (Include all family members living in home):

Signature of Applicant:_____ Date_____

Date received by Montgomery Hospice:	Signature:
Probable Eligibility Determination	Signature/Date: