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