Financial Assistance Program

We Are Here For You When You Need Us Most
Marshall Medical Centers is committed to providing world class healthcare right here at home for those we serve. Financial Assistance is the key to meeting our mission by providing help to those in our community in need.

Do I Qualify?
Please fill out the application for financial assistance and attach the documents that prove residence and income to determine if you qualify. Confidential help completing the application is available Monday-Friday between 8:00am and 4:30pm by calling Financial Assistance Representative at (256)840-3685.

How Do I Apply?
Print and complete the Financial Assistance Application, and return it with any supporting documentation to:

Marshall Medical Centers
Attn: Financial Assistance
227 Brittany Road
Guntersville, Alabama 35976

You may obtain a copy of the financial assistance application from our website or by calling the above phone number to request that on be mailed to you.

Required Documentation for Your Application:

- Proof of Residence (such as driver's license or utility bill with your current address)
- One of the Following:
  - Tax Return for previous year
  - W-2
  - 1099
  - 3 most recent check stubs
  - Letter from Employer verifying income
  - Verification of unemployment compensation
  - Verification of circumstance from person(s) providing for you
- Bank Statement (Last 30 days)

Approval Process
Based upon the information provided, please allow up to six (6) weeks to process your application. Eligibility is based on the Federal Poverty Income Guidelines and your ability to pay. Collection will continue on your account until the required documentation is returned to Marshall Medical Centers.

**This program does not apply to physician or other professional fees billed separately from hospital facility fees, with the exception of emergency medicine physicians, CRNA services, and other select providers indicated in Exhibit C of the Financial Assistance Policy. Click this link for a complete list of our emergency medicine physicians.*

https://www.mmcenters.com/services/emergency-services

***This document serves as the Plain Language Summary of the Financial Assistance Policy.*

FINANCIAL ASSISTANCE APPLICATION

Patient Name _____ Date of Birth _____

Patient Address _____

Patient Telephone Number(s)_____ Patient SSN _____

Currently Employed ____Yes ___No

If Yes, Employer Name _____

Spouse Name _____

Spouse Date of Birth _____ Spouse SSN_____

Currently Employed ___Yes ___No If Yes, Employer Name _____

Name(s) of dependent family members **under the age of 19** currently residing with you:

Name(s)	**Date(s) of Birth**	**Social Security Number(s)**

Briefly describe why you are applying for financial assistance. (Include all employment, health, disability, death, divorce, extenuating circumstances, etc)

_____

_____

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INCOME AND RESOURCES STATEMENT

Income: (Gross Amounts)	**Patient**	**Spouse**
Salary (Monthly)		
Social Security/Disability		
Child Support		
Retirement (401(k), IRA, Etc)		
Business		
Food Stamps		
Other Income		

Resources: (Current value of each):	**Patient**	**Spouse**
Checking Accounts		
Savings Accounts		
Other		

Monthly Expenses:			
Housing		Utilities	
Insurance		Child Support	
Car Payment		Credit Cards	
Medical Insurance		Medication	

To ensure full consideration of your application and to assist us in making an informed decision, the following MUST be submitted:

- Documentation of income (examples: paycheck stub(s), food stamps, federal tax return, W-9, etc)
- Proof of residence (examples: driver's license, utility bill, etc.)

I certify the above information is true and correct. I understand the information submitted herein is subject to verification and review by federal and state enforcement agencies and others as required.

Signed: _____ *(Applicant's Signature)*