MORROW COUNTY
HEALTH DISTRICT
Excellence in Healthcare

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FINANCIAL ASSISTANCE APPLICATION

RESPONSIBLE PARTY INFORMATION	
Name	**Phone Numbers**
Mailing Address	**Social Security Number**
Health Insurance Plan Information	**Insured's Name and ID number**
Current Employer	

Name	Date of Birth	Name	Date of Birth
Self		**Dependent**	
Spouse		**Dependent**	
Dependent		**Dependent**	
Dependent		**Dependent**	

Annual Family Income – Enter actual dollar amounts

Source of Income	Self	Spouse	Dependent	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, VA benefits				
Alimony, child support, military allotments				
Income from self employment				
Rent, interest, dividends, and other income				
TOTAL INCOME				

Documentation required to be submitted with application

Identification (Provide one)	Driver's license, state ID card, or other photo ID	
Insurance	Insurance cards, pending application for insurance, or evidence of coverage denials if applicable	
Income (Provide all)	▪ 3 most recent pay stubs for all members of household ▪ 3 most recent bank statements ▪ Prior year tax return ▪ Social Security Benefits Summary (if applicable)	

I certify that the family size and income information shown above is correct.

Name (Print)	Date

Signature

OFFICE USE ONLY		
Patient Name(s)		
Date Approved	**Discount %**	**Approved by**