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Marshall Medical Centers
Many Reasons. One Choice.

Financial Assistance Program

Marshall Medical Centers
227 Brittany Road
Guntersville, AL 35976

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 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, income, assets or other resources to determine if you qualify. Confidential help completing the application is available Monday-Friday between 8:00 a.m. and 4:30 p.m. by calling Tiffany Mason at 256-571-8125 (256-753-8125 for Arab area).

How Do I Apply?

Print and complete the Financial Assistance Application, and return it along with any supporting documentation to:

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

Required Documentation For Your Application

- ☐ Proof of Residence (such as driver's license or utility bill with your current address)
- ☐ Proof of Income
- ☐ One of the Following:
  - Tax Return for previous year
  - W-2
  - 1099
  - Letter from employer verifying income
  - Verification of unemployment compensation
  - Verification of circumstances from person(s) providing for you
- ☐ Approval letter if you are receiving food stamps or other assistance
- ☐ Any and all other sources of income

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. If the supporting documentation is not submitted with the application and/or falsification of any portion of the application is identified, your application will be denied. Marshall Medical Centers reserves the right to reverse financial assistance when information is presented indicating the patient/guarantor has the ability to pay for services and financial assistance should not have been approved.

**This program does not apply to physician or other professional fees billed separately from hospital facility fees or emergency medicine physicians. Click this link for a complete list of our emergency medicine physicians.*

http://www.mmcenters.com/index.php/find_physician/physician_by_specialty_detail/Emergency%20Medicine

Requirements and Instructions

Below you will find a three (3) page Financial Assistance Application for service(s) to be provided for you by Marshall Medical Centers. Any information you provide will enable us to make a determination regarding your eligibility for assistance.

- ☐ All pertinent supporting documentation must be submitted to be considered for assistance. *(*Incomplete applications will be rejected, and payment in full will become due.)*
- ☐ Once completed, mail application and all pertinent supporting documentation to the address listed below.
- ☐ If you received this application by mail, it must be completed ***in its entirety*** and returned to Marshall Medical Centers within 21 days of your receipt of same.

Upon receipt of the completed application, you will be notified in writing as to the status of your request for assistance. This process may take up to six (6) weeks.

Thank you for choosing Marshall Medical Centers. Should you need assistance with this application, please feel free to contact our Financial Assistance Representative at: 256-571-8125 (256-753-8125 for Arab area).

Marshall Medical Center North ( )
Marshall Medical Center South ( )

FINANCIAL ASSISTANCE APPLICATION

Patient Name _____ Date of Birth_____

Patient Address _____

Number of years having resided there _____

Patient Telephone Number(s) _____ Patient SSN_____

Responsible Party (*Name)* _____

Responsible Party (*Date of Birth)* _____

Responsible Party (*Address)* _____

Name(s) of family members currently residing with you: _____

_____

_____

_____

EMPLOYMENT

Are you currently: Employed ( ) Unemployed ( )

List current employment or last employment below:

_____

Patient's Employer Address Phone Number

_____

Position Number of years there

_____

Responsible Party Employer Address Phone Number

_____

Position Number of years there

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

_____

_____

_____

INCOME AND RESOURCES STATEMENT

INCOME:

	PATIENT	*SPOUSE AND/OR RESPONSIBLE PARTY*
Salary (monthly)	_____	_____
Social Security	_____	_____
SSI/Disability	_____	_____
Retirement	_____	_____
Business	_____	_____
Food Stamps	_____	_____
Other Income	_____	_____

TOTAL COMBINED INCOME: _____

RESOURCES:
(Current value of each resource)

	PATIENT	*SPOUSE AND/OR RESPONSIBILITY PARTY*
Checking Accounts	_____	_____
Savings Accounts	_____	_____
Other Property	_____	_____
Other	_____	_____

Is home paid for? Yes ( ) No ( )

Buying home? _____ Renting? _____ Payment Amount _____

MONTHLY EXPENSES:

Housing	$_____	Food	$_____
Insurance	$_____	Child Support	$_____
Car Loan	$_____	Credit Cards	$_____
Land Loan	$_____	Physician/Dental	$_____
Utilities	$_____	Medications	$_____

** For Internal use only**

Monthly Income$_____
Monthly Expenses$_____

Difference$_____

*SUPPORTING DOCUMENTATION: **READ CAREFULLY***

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

- ☐ Documentation of income (including: paycheck stub(s), food stamps, etc.)
- ☐ Federal Tax Return or W-2 for previous year
- ☐ Credit card statement for current or previous month
- ☐ Proof of residence (including: driver's license, utility bill, etc.)

*(*You may use the bottom or back of this form, or include attachments for your response.)*

I certify the above information is true and correct. I understand the information submitted herein is subject to verification and review by the Federal & State Enforcement Agencies and other as required.

Signed: _____ Date :_____

Applicant's Signature

***If supporting documentation is not provided with this application, financial assistance will be denied. Application MUST be completed in its entirety and returned to the address on the front page within 21 days*