



Petersburg Medical Center


103 Fram Street
PO Box 589
Petersburg, Alaska 99833

Phone: 907-772-4291
Fax: 907-772-3085

If you feel that you are unable to make monthly payments, pay your balances in full, or have had a catastrophic event or extenuating circumstance, you may qualify for Financial Assistance.

If your application is approved, a percentage of your balances may be written off.

Steps to apply for Financial Assistance:

- Apply for Medicaid and produce a copy of the submitted application
 -  Exceptions:
 - Your primary residence is out of state.
 - You already have Medicaid.
 - You have been recently denied Medicaid; proof will be needed.
- Complete the enclosed application as best and fully as capable.
- Return the enclosed application and necessary documents to the Business Office, Nurses' Station or Clinic Reception.

Once all of the necessary documentation has been returned, your application will be reviewed by our CFO and you will be notified of a decision for your case within 14 business days.

If you need assistance in completing this application, or have questions regarding payment or your bills, please do not hesitate to contact the Business Office at 907-772-4291. We are here to assist you.

Thank you

**PLEASE KEEP A COPY OF YOUR
COMPLETED APPLICATION FOR YOUR RECORDS**

Please complete the following application to apply for Financial Assistance through Petersburg Medical Center. If you feel that you may not require complete financial assistance, please contact our office to set up an interest free payment plan. Our business office staff will be more than happy to assist you in this process.

The following information is required in order for our office to make the best decision for your situation. Please be honest and fill out the application fully and to the best of your knowledge. Providing false information may result in the DENIAL of any type of Financial Assistance through Petersburg Medical Center.

1. Medicaid Application: If you are in the state of Alaska, applying for Medicaid is a requirement. Please enclose a copy of the completed application with this packet. As soon as you know the determination of whether you have been approved or denied, please contact our office.
2. Please include the following documents with this application. Failure to include this documentation may result in rejection of your application.
 - a. 2018 Federal income tax returns and W-2 forms
 - b. Copies of your previous 2 bank statements
 - c. Pay stubs for the previous 2 months

Please complete the enclosed Financial Statement from the following sources:

- | | |
|---|--|
| <input type="checkbox"/> Gross Wages | <input type="checkbox"/> Unemployment Compensation |
| <input type="checkbox"/> Child Support and/or Alimony | <input type="checkbox"/> Financial Aid/Grants/Scholarships |
| <input type="checkbox"/> Self Employment Income | <input type="checkbox"/> Pensions |
| <input type="checkbox"/> Military Family Allotments | <input type="checkbox"/> Strike Benefits |
| <input type="checkbox"/> Public Assistance | <input type="checkbox"/> Housing Subsidies |
| <input type="checkbox"/> Rental Income | <input type="checkbox"/> All other taxable income |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Permanent Fund Dividends |
| <input type="checkbox"/> Income from Interest Dividends | <input type="checkbox"/> Workers Compensation |

Application Due Date: _____

Your application is due to Petersburg Medical Center by this date. Until this application has been returned, your accounts are subject to our normal collections process; which may result in being turned over to a collection agency. **If you need assistance please contact our Business Office at (907) 772-4291 Monday – Friday 8am to 5pm, or stop by our office.** We look forward to working with you.

Petersburg Medical Center
Financial Assistance Application

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Patient Information

Patient's Name: _____ Social Security Number: _____
Address: _____ Home Telephone: _____
City: _____ State: _____ Zip: _____ Work Telephone: _____
Date of Birth: _____

Guarantor Information

Guarantor's Name: _____ Relationship to Patient: _____
Address: _____ Social Security Number: _____
City: _____ State: _____ Zip: _____ Home Telephone: _____
Date of Birth: _____ Work Telephone: _____
Current Employer: _____
Spouse Current Employer: _____

Dependents

Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

Monthly Income (Proof of income must be attached)

Family Income: (Submit last 3 consecutive pay stubs & most recent W-2 forms)

Guarantor Wages:	Spouse Wages:	Parents (if applicable):
Social Security:	Pension:	
Food Stamps:		
Other:		

Total Monthly Income: _____

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Monthly Expenses

Rent/Mortgage:	Utilities:	Heating Fuel:
Telephone:	Food:	Transportation (gas/bus/taxi):
TV:	Insurance:	Medicines:
Clothing:	Equipment Rental:	Medical Visits:
Child Care:	Other:	

Loans

Automobile:

Lender's Name:	Account #:	Monthly Payment:
Lender's Name:	Account #:	Monthly Payment:

Second Mortgage:

Lender's Name:	Account #:	Monthly Payment:
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Student Loans:

Lender's Name:	Account #:	Monthly Payment:
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Credit Cards:

Lender's Name:	Account #:	Monthly Payment:
Lender's Name:	Account #:	Monthly Payment:
Lender's Name:	Account #:	Monthly Payment:
Lender's Name:	Account #:	Monthly Payment:

Other:

Lender's Name:	Account #:	Monthly Payment:
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Total Loan Payments: _____

Total Monthly Expenses: _____

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Assets

Bank Accounts:

Checking:	Bank Name:	Account #:	Balance:
Checking:	Bank Name:	Account #:	Balance:
Savings:	Bank Name:	Account #:	Balance:
IRA:	Bank Name:	Account #:	Balance:
401K:	Bank Name:	Account #:	Balance:
TSA	Bank Name:	Account #:	Balance:
Other:	Bank Name:	Account #:	Balance:
Other:	Bank Name:	Account #:	Balance:

Vehicle(s): Auto, boat, camper, trailer

Year	Make	Model	Value
Year	Make	Model	Value
Year	Make	Model	Value

Property

Address	Mortgage Balance	Value
Address	Mortgage Balance	Value

Other Assets

Type	Value

Please give a brief description of your financial situation and any future known medical needs: _____

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Financial Responsibility

I certify that the above information is true and accurate to the best of my knowledge. I understand that payment of this bill is my responsibility and that the information provided is for Petersburg Medical Center to review my case for financial assistance. By signing below, I constitute permission for Petersburg Medical Center to verify any information provided, including a credit check, when applicable. If any information I have given proves to be false, I understand that Petersburg Medical Center will require payment in full of this debt.

Guarantor signature: _____ Date: _____