Petersburg Medical Center
P.O. Box 589
Financial Assistance Application
Petersburg, AK 99833

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. 2015 & 2016 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:

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

Application Due Date:_____

Your application is due to Petersburg Medical Center by this date. Failure to meet this deadline will result in your accounts being 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. We look forward to working with you.

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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: _____

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

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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:

Student Loans:

Lender's Name:	Account #:	Monthly Payment:

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:

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:_____

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