103 Fram Street
PO Box 589
Petersburg, AK 99833
Phone: (907)772-5730
Fax: (907)772-3085
Email: financialservices@pmc-health.org

Petersburg Medical Center

Presumptive Financial Assistance

SCREENING INFORMATION

Do you have Medicaid?
YES: If so, which state? _____ Medicaid ID #_____
NO:

Are you homeless? Yes: _____ No:_____
Do you receive any state public assistance services, such as WIC, food stamps, TANF, HUD Section 8 Housing?
YES: If so, what services and from which state?
NO:
If you answered NO to both above questions you will need to fill out the standard Financial Assistance Application and provide proof of income.

PATIENT / APPLICANT INFORMATION

Patient's Full Name (First, Middle, Last):	
Patient's Date of Birth:	
Person Responsible for Paying the Bill (Guarantor):	**Patient's Gross Monthly Income:**
List Any Dependents and Date of Birth:	**Patient's Sources of Income:**
Mailing Address: _____ _____ **City State Zip**	**Main Contact Numbers:** ( ) ( ) **Email address:**

PATIENT AGREEMENT

Financial Responsibility
By signing below, I certify the above information is true and accurate to the best of my knowledge. The information provided is to review my case for financial assistance. I understand that Petersburg Medical Center may verify the information provided. If the information I gave is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for the services provided. If the patient is unable to sign a representative can certify by signing P.P. and then their signature.

Guarantor Signature:	**Date:**