Fitzgibbon Hospital
Patient Accounts
2305 S. Highway 65, P.O. Box 250
Marshall, MO 65340
(660) 831-3730

Dear Patient/Guarantor:

A request has been made that you be evaluated for financial assistance on your outstanding bills with Fitzgibbon Hospital and/or its employed medical providers. Consideration for assistance will be based on your household annual income and family/household size.

All sources of payment must be exhausted before financial assistance is considered. Examples of payments would be all medical insurances, third party and liability claims. Should you qualify for financial assistance, you will be responsible for any patient convenience items.

To process this request for assistance, we need your immediate cooperation in providing the following information:

- A completed financial assistance application
- A copy of your last year's federal income tax return
- Three prior period income verification (i.e., paycheck stub)
- A copy of last month's bank statement *(optional for National Health Services Corps sites)*

If you need assistance or more information, please call Patient Accounts at (660) 831-3730.

Fitzgibbon Hospital and Clinics
Marshall, MO

REQUEST FOR FINANCIAL INFORMATION

Date of Request:_____

PATIENT NAME	AGE	PHONE NO.	PATIENT SOC. SEC. #
			Optional
GUARANTOR NAME	**AGE**	**RELATION TO PATIENT**	**SOC. SEC. #**
			Optional
SPOUSE NAME	**AGE**	**PHONE NO.**	**SOC. SEC. #**
			Optional

APPLICANT ADDRESS		NEXT OF KIN	
STREET		NAME	PHONE NO.
CITY, STATE, ZIP		ADDRESS – STREET, CITY, STATE, ZIP	
GUARANTOR EMPLOYER		**SPOUSE EMPLOYER**	
NAME	PHONE NO.	NAME	PHONE NO.
ADDRESS		ADDRESS	
POSITION / TITLE	HOW LONG EMPLOYED?	POSITION / TITLE	HOW LONG EMPLOYED?
GROSS MONTHLY INCOME	**$**	**GROSS MONTHLY INCOME**	**$**
PAYDAY: _____Weekly _____Every other week _____1st & 15th _____Once a month		PAYDAY: _____Weekly _____Every other week _____1st & 15th _____Once a month	

INCOME	GUARANTOR	SPOUSE
Wages / Salary		
Social Security / Pension		
Rental Income		
Alimony / Child Support		
Other Government Assistance / Public Assistance		
Unemployment		
Total Monthly Income	**$**	**$**

Number of Dependents, per Federal Income Tax, living in your home	**#**

I/We certify that the above statements and financial information are true and correct as of this date.

Signature of Responsible Party	Signature of Spouse
X	**X**