MRH Marlette Regional Hospital
an affiliate of
UNITED HEALTHCARE PARTNERS

2770 Main Street | P.O. Box 307 | Marlette, MI 48453
989-635-4000 | marletteregionalhospital.org

Application for Assistance & Financial Disclosure Statement

Patient Name: _____
Address: _____
Phone: _____ Occupation: _____
Employer: _____ Phone: _____
Employer Address: _____

Household Income for Family in Last 12 Months

Wages: _____
Child Support/Alimony: _____
Unemployment Compensation: _____
Public Assistance: _____
Social Security: _____
Worker's Compensation: _____
Pensions: _____
Income from dividends, rent, or interest: _____

Family Size

Name:	Relationship:
_____	_____
_____	_____
_____	_____

Type of Service Required: _____
Estimated Cost: _____ Account # _____

I affirm that the above information is true and correct to the best of my knowledge.

Date: _____ Signature: _____