MPTF
MOTION PICTURE & TELEVISION FUND

APPLICATION FOR HOSPITAL CHARITY

(Answers to the following questions should reflect financial information of both the applicant and the applicant's significant other, if married, separated, or in a domestic partnership.)

Patient Account Number(s) _____

Applicant Name _____ SSN _____ Birthdate _____

Spouse/Partner Name _____ SSN _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Telephone _____ E-Mail _____

Family Size _____

OTHER INFORMATION

MEDICAL INSURANCE – Please provide a photocopy the patient's medical insurance cards.

Primary Insurance _____Policy# _____

2nd Insurance_____ Policy# _____

Prescription Drug Plan _____Policy#_____

Other Coverage _____

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INCOME

PENSION, SOCIAL SECURITY, RENTAL INCOME, DIVIDENDS, INTEREST INCOME, ALIMONY, ETC. – Please list all income sources for each family member below. You must also provide proof of income by submitting a copy of your most recent year's federal tax return. If unable to provide federal tax return, provide most recent employer pay stubs (last 3 months) or written documentation from other income sources.

1. Name on Check_____ Issued by_____

   Amount_____ per _____

2. Name on Check_____ Issued by_____

   Amount_____ per_____

3. Name on Check_____ Issued by_____

   Amount_____ per_____

4. Name on Check_____ Issued by_____

   Amount_____ per_____

I hereby certify that I have answered the foregoing questions to the best of my ability, without any mental reservations whatsoever, that the facts therein stated are true and I understand that any misrepresentation of this information will disqualify me for charity care at MPTF Acute Psychiatric Hospital.

I hereby authorize MPTF to communicate with responsible relatives, to secure information regarding income, to contact financial institutions for financial data, and to contact any other agency or persons regarding my financial status.

I further agree to notify MPTF of any change in my financial situation.

Signature of Applicant _____ Date _____

Signature of Spouse/Partner_____ Date _____

Return completed application and documents to the hospital at the address on your bill.