Murray County Medical Center
2042 Juniper Ave * Slayton, MN 56172

SLIDING FEE DISCOUNT APPLICATION

IN ORDER TO CONSIDER YOUR APPLICATION, PLEASE RETURN A COMPLETED AND SIGNED APPLICATION INCLUDING THE REQUIRED PROOFS THAT APPLY TO YOU FROM THE CHECKLIST ATTACHED.

A. (CIRCLE ONE) *Single* *Married* *Separated* *Divorced* *Widowed*

Last Name	First Name	MI	Social Security #
Spouse Name	First Name	MI	Social Security #

Address	City	State	Zip Code
Home Phone	Cell Phone	e-mail address	

Applicant Occupation	Employer	Hourly Wage/Salary	FT/PT
Spouse Occupation	Employer	Hourly Wage/Salary	FT/PT

B. PLEASE INDICATE ALL DEPENDENTS: (USE EXTRA PAPER IF NEEDED)

Name (Last name, First name)	DOB
1	
2	
3	
4	

C. Income

		Office use only
Gross Wages/Salary (Before taxes MONTHLY)	$	$
Income from Self Employment	$	$
Income from Farm	$	$
Income from Social Security	$	$
Income from Unemployment	$	$
Income from Workers Comp	$	$
Alimony	$	$
Child Support	$	$
Other (Please specity)	$	$
TOTAL INCOME	$	

Please answer the questions below.

Have you ever applied for the Sliding Fee Discount with our facility before? If so, when? _____

Have you inquired about payment arrangements for your outstanding balance? _____

If you are able to make monthly payments, how much could you afford to pay each month? _____

Other Comments:

Please inform us of any additional information you would like us to consider when processing your application.

_____

_____

_____ Please check here if you have attached additional pages.

ASSIGNMENT OF RIGHTS (PLEASE READ CAREFULLY)

I understand that information and statements I have provided will be kept confidential by Murray County Medical Center.

By signing below, I understand that I have the obligation to provide complete and truthful information to Murray County Medical Center, and to cooperate with any of the facility's requests for verification and additional information. I understand that completion of this application will allow Murray County Medical Center to consider my circumstances, and Murray County Medical Center makes no representations that a discount is guaranteed.

_____ _____

Signature Date

Applications must be returned within 30 days.

If you are submitting your application for
Sliding Fee Discount
via U.S. Mail

please send to:

Murray County Medical Center
Attn: Lisa S.
2042 Juniper Avenue
Slayton, MN 56172

Ph: 507-836-1261

Email: sweetmanl@murraycountymed.org

For Office Use Only

Reviewed by: _____

Date: _____

Approved Denied

Reason If Denied: _____

If Approved:

CFO Signature: _____

Date: _____