

McCall Memorial Hospital  
Charitable Assistance Application

**Guarantor (Head of Household) Information:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Years at Current Residence: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Years @ this job: \_\_\_\_\_

Employer Address & Phone: \_\_\_\_\_  
\_\_\_\_\_

Supervisor's Name & Phone: \_\_\_\_\_

**Spouse Information:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Years at Current Residence: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Years @ this job: \_\_\_\_\_

Employer Address & Phone: \_\_\_\_\_  
\_\_\_\_\_

Supervisor's Name & Phone: \_\_\_\_\_

**Dependent Information:**

Using legal names (no nic-names), please list everyone (including yourself) living at your address.  
Please use additional sheet of paper if needed.

Name	Relationship to You	Age

**INCOME INFORMATION: must attach supporting documentation.**

	Average Monthly Figures GUARANTOR	Average Monthly Figures SPOUSE
Gross Salary &/or Wages:	\$ _____	\$ _____
Net Farm &/or Self-Employed:	\$ _____	\$ _____
Alimony &/or Child Support:	\$ _____	\$ _____
Social Security:	\$ _____	\$ _____
Pension &/or Retirement/VA:	\$ _____	\$ _____
Rental Income:	\$ _____	\$ _____
Tips:	\$ _____	\$ _____
Unemployment:	\$ _____	\$ _____
Public Assistance:	\$ _____	\$ _____
Disability &/or Worker's Comp:	\$ _____	\$ _____
Interest &/or Dividends:	\$ _____	\$ _____
<b>TOTAL MONTHLY INCOME:</b>	<b>\$ _____</b>	<b>TOTAL MONTHLY INCOME: \$ _____</b>

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**MONTHLY EXPENSES (Average)**

Housing ( ) Rent? \$ \_\_\_\_\_ Amount ( ) Own? \$ \_\_\_\_\_ Mortgage Amount

Name of Landlord or Mortgage Company: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Mortgage Account #: \_\_\_\_\_

Food: \$ \_\_\_\_\_ Phone: \$ \_\_\_\_\_ Utilities: \$ \_\_\_\_\_

Auto Maintenance: \$ \_\_\_\_\_ Auto Ins: \$ \_\_\_\_\_ Other Ins: \$ \_\_\_\_\_

Clothing: \$ \_\_\_\_\_ Daycare: \$ \_\_\_\_\_ Child Support: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

**ASSETS:**

Name of Financial Institution: \_\_\_\_\_

Branch: \_\_\_\_\_ Phone #: \_\_\_\_\_

Account Numbers  
Savings: \_\_\_\_\_ Checking: \_\_\_\_\_ Other: \_\_\_\_\_

Balance: \$ \_\_\_\_\_ Balance: \$ \_\_\_\_\_

Cash on Hand: \$ \_\_\_\_\_

Address of Non-Primary House & Property: \_\_\_\_\_

Vehicles: \_\_\_\_\_

RVs: \_\_\_\_\_

**LOANS AND OBLIGATIONS:**

(Car, Furniture, Recreational Vehicles, Boat, Credit Cards, Credit Lines, etc.)

Creditor Name	Description	Account Number	Credit Limit	Current Balance	Monthly Payment

**OTHER OBLIGATIONS**

(Doctor, Dentist, Collection Agency, etc.)

Creditor Name	Description	Current Balance	Monthly Payment	Comment

Are there other expenses you would like us to consider?  
\_\_\_\_\_  
\_\_\_\_\_

The information listed herein is true and complete to the best of my knowledge. I give permission to McCall Memorial Hospital to verify any or all of the information listed in this application.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date