Monongahela Valley Hospital
MVH Care Application

Answer Each Question.

Use "None", if Applicable

Please Attach a Copy of Your Most Recent Federal Tax Form (1040), Current Pay Verification, and/or Social Security Determination.

Please Return all forms to:

Manager Financial Counseling
& Collections
Monongahela Valley Hospital
1163 Country Club Road
Monongahela, PA 15063-9900

Patient Name: _____

Spouse's Name: _____

Address: _____

_____

_____

Number Of Children Living At Home (0-21 Years of age): _____

Number Of Dependants Other Than Children Listed Above: _____

Guarantor/Patient Name: _____

Home Phone Number: _____

MVH Account #: _____ Balance: _____

MVH Account #: _____ Balance: _____

MVH Account #: _____ Balance: _____

Total Balance (All Accounts): _____

Preferred Calling Time: _____

I. HOUSEHOLD INCOME (MONTHLY)

A. WAGES

1. Total wages of patient/guarantor: _____
   (Attach copy of paycheck stub)
2. Employer Name: _____
3. Employer Address: _____
   _____
   _____
4. Spouse's Name: _____
5. Total Wages of Spouse: _____
   (Attach copy of paycheck stub)
6. Spouse's Employer Name: _____
7. Employer Address: _____
   _____
   _____

II. OTHER INCOME

A. Disability Payments: _____

B. Alimony/Child Support: _____

C. Retirement Benefits: _____

D. Investment Income: _____

E. Other: _____

III. TOTAL MONTHLY INCOME

$ _____

IV. HOUSEHOLD ASSETS

A. REAL PROPERTY / RESIDENCE / OTHER

1. Address: _____
   _____
2. Rent: _____ Own: _____
3. Market Value: _____
4. Mortgage Balance: _____
5. Net Value Property: _____
6. Mortgage Bank: _____
7. Address: _____
   _____

B. AUTOMOBILE

1. Make: _____ Model: _____ Year: _____
2. Loan Balance (Principle): _____
3. Loan Balance: _____
4. Net Value: _____

C. OTHER ASSETS (AT MARKET VALUE)

1. Savings Account Number: _____
   a. Balance: $ _____
2. Checking Account Number: _____
   a. Balance: $ _____
3. Certificate of Deposit Bank Name: _____
   a. Balance: $ _____
4. Insurance Cash Value: _____
5. Stocks, Bonds, Other: _____
   a. Source: _____
   b. Cash Value: $ _____

ALL OF THE INFORMATION IS TRUE AND COMPLETE, AND MAY BE VERIFIED WITH THE LISTED INSTITUTIONS. I REQUEST EACH LISTED INSTITUTION TO RELEASE ALL OF MY PERSONAL ACCOUNT BALANCE INFORMATION TO MONONGAHELA VALLEY HOSPITAL IN ORDER TO VERIFY THE BALANCES/AMOUNTS LISTED.

Date _____ Signature of Applicant _____

FOR HOSPITAL USE ONLY

TOTAL NET SCHEDULED ASSETS $ _____