Community Assistance Application

You may be eligible for financial assistance to pay for medical services received at Memorial Hospital. If your income falls within the amounts in the table below according to the size of your family, you may apply for assistance.

Family Size	Gross Income $
1	54,360
2	73,240
3	92,120
4	111,000
5	129,880
6	148,760
7	167,640
8	186,520

Add $4,720 for each additional person in your family.

Please submit the following information to the address below within 60 days of the service you received at Logansport Memorial Hospital.

Required Information:

1. **Patient Name:** _____
2. **Date of Service:** _____
3. **Number of people living in your household:** _____
4. **Household Income:** _____
5. **Copy of a paycheck stub or last year's W-2 form**.

If this application has not been submitted in a timely manner, your full payment will be due within 30 days of receiving your bill.

For your convenience, cash, check, MasterCard, Visa or Discover will be accepted as payment options.

For questions, to send information, or to make payment arrangements on your account, contact:

FINANCIAL COUNSELOR
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