



# 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:**

Robert McClure  
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 \_\_\_\_\_

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FOR HOSPITAL USE ONLY

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TOTAL NET SCHEDULED ASSETS \$ \_\_\_\_\_