MATERNAL GRANT APPLICATION

Mail to: MSC # 133, 777 Hemlock St, Macon, GA 31201
Or Fax to: 478-633-7576

Patient Name: _____ Account #: _____

Address: _____

Birthdate: _____ Phone #: _____ County of Residence: _____

PATIENT	**SPOUSE/OTHER**
Name:	Name:
Place of Employment:	Place of Employment:
Hourly Rate:	Hourly Rate:
Child Support:	Child Support:
Disability/Unemployment:	Disability/Unemployment:
Gross Annual Income:	Gross Annual Income:

Total number of people in family/household _____

Name of People in Household	**Age**	**Relationship to Patient**

(use back of form if more than 7 people in household)

Did your baby spend any time in the Intensive Care Nursery or Level II Nursery? ____Yes ____No ___Not applicable

This is the total and accurate account of my household annual income. I have attached documentation of income for every income-earner in my household. I hereby authorize the Medical Center, Navicent Health to obtain and verify my annual income with my employer and/or any other source of income.

_____ _____

Patient's Signature Date Spouse/Other Signature Date

Approved:_____ **Denied:**_____ **Reason for denial:**_____