PERSONAL FINANCIAL STATEMENT FOR FINANCIAL ASSISTANCE

Patient Name	Age	Phone Number	Marital Status S M W D	Social security Number

Date Pt. Received:	Acct. #/Balance: /$	; Acct. # / Balance: /$
Please Return by:	Acct. #/Balance: /$	; Acct. # / Balance: /$
Date Returned:	Acct. #/Balance: /$	; Acct. # / Balance: /$

Patient	Person Responsible for bill: *(if not patient)*	Relationship
Street:	Name:	
City, State, Zip	Street:	
	City, State, Zip	
Phone: ( ) Cell: ( )	Phone : ( ) Cell: ( )	

EMPLOYMENT

Patient's Employer:	Guarantor's Employer:
Occupation:	Occupation:
If unemployed, name of last employer:	If unemployed, name of last employer:
How long unemployed?	How long unemployed?

LIST BELOW ALL MEMBERS OF HOUSEHOLD BEGINNING WITH PATIENT

NAME	AGE	RELATIONSHIP TO PATIENT

DO YOU HAVE HEALTH INSURANCE COVERAGE AVAILABLE? YES NO

IF YES, WHY NOT AVAILABLE FOR THIS DATE OF SERVICE?____

____

IF NO, PLEASE INDICATE THE REASON FOR LACK OF INSURANCE COVERAGE.

IS THE INSURANCE COST TO HIGH? YES NO

PRE-EXISTING CONDITION? YES NO

OTHER, PLEASE DESCRIBE: ____

HAVE YOU APPLIED FOR MEDICAID? YES NO

IF DENIED, DATE: ______________________ REASON FOR DENIAL: ______________________

IF DENIED, PLEASE ATTACH A COPY OF MEDICAID DENIAL LETTER.

MONTHLY INCOME: Attach Copies of Proof of Income *(i.e. tax return)*

	Patient	Spouse	Other Members of Household *(18 or older)*
Wages (Gross)	$	$	
Social Security			
Pensions			
Unemployment/Work Comp			
Alimony/Child Support			
Government Assistance			
Disability Payments			
Dividends/Interest			
Other, List…			
MONTHLY INCOME SUBTOTAL:			
TOTAL INCOME: $	**MONTHLY: $**		**YEARLY: $**

EXPENSES	**MONTHLY**	**BALANCE DUE**	**HOUSEHOLD ASSETS**	**VALUE**
Mortgage or Rent Payment	$	$	Savings *(attach copy)*	$
Car Payment			Checking *(attach copy)*	
Utilities *(Gas, Electric, Water)*			Stocks and Bonds	
Cable			Mutual Funds, Money Market, etc	
Phone *(including cell)*			Cash Value of Life Insurance	
Food			Real Estate Value	
Child Care			Farming Real Estate Value	
Clothing			Vehicles Value *(not primary)*	
Insurance			Jewelry & Other Personal Property	
Gas/Transportation			Other Assets *(Describe)*	
Recreation				
Physicians				
Hospitals				
Other Medical				
Credit Cards				
Other Expenses *(Describe)*			**TOTAL HOUSEHOLD ASSETS:**	$
			HOUSEHOLD DEBTS	VALUE
			Home Loan	$
			Auto Loan	
			Credit Card Debt	
			Other: *Total Expenses from "Balance Due" column – (Mortgage + Car Loan = Credit Cards)*	
TOTAL EXPENSES:	**$**	**$**	**TOTAL HOUSEHOLD DEBTS:**	**$**

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

I verify the information provided is correct and complete. I authorize verification of any information and understand that additional documentation may be requested. If any information if found to be false, financial arrangement or assistance may be voided.

Patient/Responsible Party Signature Date:

Application Determination: APPROVED / DENIED Date Determination Letter Mailed: ______________

Reason for Denial: ____

Hospital Representative Signature(s)____ Date:______________________