PATIENT FINANCIAL APPLICATION

Date _____ PC# _____ Account#(s) _____

This application must be completed to the best of your knowledge. Additional information may be required.

Name _____ Date of Birth _____/_____/_____
Last First Middle Soc Sec# __ __ __ - __ __ - __ __ __ __

Spouse's _____ Date of Birth _____/_____/_____
Last First Middle Soc Sec# __ __ __ - __ __ - __ __ __ __

_____ Phone Number _____
Street City State Zip

Residence County _____

# of Dependents (not including self) and ages _____

Are you buying/renting? _____ Amt Paid $_____ How long at this address? _____

EMPLOYMENT INFORMATION

Name of employer _____

Address _____

Approx hire date_____ Monthly pay_____

Full-time/part-time_____ Deductions other than taxes $_____

SPOUSES'S EMPLOYMENT INFORMATION

Name of employer _____

Address _____

Approx hire date_____ Monthly pay_____

Full-time/part-time _____ Deductions other than taxes $_____

ASSETS

Where do you bank? _____ Checking balance $_____ Savings balance $_____

Stocks/Bonds/CDs _____ Life Insurance Company _____ Face Value $_____

Home and/or other real estate _____ Market value $ _____ Amount Owed _____

Vehicle(s) (make/year) _____ Lein holder on vehicle(s) _____

Do you own other real estate? _____ If yes, where? _____ Value$ _____

List any recreational vehicles you own _____

HEALTH INSURANCE INFORMATION

Do you have health insurance? _____ If "Yes", is your health insurance obtained through your employer? _____

If "No", does your employer offer health insurance? _____ Name of Insurance Co. _____

Address _____ Phone Number _____
Street City State Zip

Policy Holder Name _____ Policy Number _____

CREDIT INFORMATION

(List all installment loans, credit cards, medical, doctor bills, etc.)

List all debts	To Whom	Amount	Monthly Pmt	Balance
Mortgage/Rent				
Auto				
Credit Card				
Credit Card				
Finance Co/Bank				

Monthly household expenses

Food _____ Electric _____ Gas _____ Water _____ Cable _____

Phone _____ Prescription Medicines _____ Alimony/Child support _____

Other Expenses by month

Insurance premium, Health _____ Insurance Premium, auto _____

Insurance premium, home _____ Personal property & real estate taxes _____

Transportation (gas, bus fare, etc.) _____ Other _____

Monthly Income

Husband _____ Wife _____ Other _____

Total Monthly Income _____ Total expenses listed above _____ = _____

Based on the above Financial Statement, I/We are proposing to pay $_____ per month.

PLEASE READ AND SIGN BELOW

I certify that the information given on this application and any attached supporting documention is accurate and complete to the best of my ability. I authorize the Hospital/Clinic to investigate in reviewing my application for financial assistance.

Responsible Party's Signature _____ Date _____

Spouse's Signature _____ Date _____

For office use only

Approved by: _____ Date _____