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:	
		Street	
City, ST, Zip		City, ST 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? Insurance cost too high? Yes_____ No_____;
Pre-existing condition? Yes_____ No_____; Other, please describe _____

Have you applied for Medicaid? Yes_____ No_____ Date Applied: _____

If denied, date: _____ Reason for Denial: _____

If denied, please attach a copy of the Medicaid denial letter.

MONTHLY INCOME: Attach Copies of Proof of Income			
	Patient	Spouse	Other Members of Household (18 and 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
Mortgage or Rent Payment	$	$
Car Payment		
Utilities (Gas, Electric, Water		
Cable		
Phone (Including Cell)		
Food		
Child Care		
Clothing		
Insurance (Auto, Life, Health)		
Gas/Transportation		
Recreation		
Physicians		
Hospitals		
Other Medical		
Credit Cards		
Other Expenses (Describe)		
TOTAL EXPENSES:	$	$

HOUSEHOLD ASSETS	VALUE
Savings	$
Checking	
Stocks and Bonds	
Mutual Funds, Money Marekt, etc.	
Cash Value of Life Insurance	
Real Estate Value	
Farming Real Estate Value	
Vehicles Value (not primary)	
Jewelry & Other Personal Property	
Other Assets (Describe)	
TOTAL HOUSEHOLD ASSETS:	$

HOUSEHOLD DEBTS	VALUE
Home Loan	$
Auto Loan	
Credit Card Debt	
Other: Total Expenses from "Balance Due"	
column - (Mortgage + Car Loan + Cr, Cards)	
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 IS 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: