

## Personal Financial Statement for Financial Assistance

<b>Patient Name:</b>	<b>Age</b>	<b>Phone Number</b> (____)-____-____	<b>Marital Status</b> S M W D	<b>Social Security Number</b> ____ - ____ - ____
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<b>Date Pt. Received:</b>	<b>Acct #:</b>	<b>Balance:\$</b>
<b>Please Return By:</b>	<b>Acct #:</b>	<b>Balance:\$</b>
<b>Date Returned:</b>	<b>Acct #:</b>	<b>Balance:\$</b>

<b>Patient</b>	<b>Person Responsible for Bill (if not patient)</b>	<b>Relationship</b>
<b>Street:</b>	<b>Name:</b>	
<b>City, ST, Zip</b>	<b>City, ST, Zip</b>	
<b>Phone: (____)-____-____</b> <b>Cell: (____)-____-____</b>	<b>Phone: (____)-____-____</b> <b>Cell: (____)-____-____</b>	

### EMPLOYMENT

<b>Patient's Employer:</b>	<b>Guarantor's Employer:</b>
<b>Occupation:</b>	<b>Occupation:</b>
<b>If unemployed, Name of Last Employer:</b>	<b>If unemployed, Name of Last Employer:</b>
<b>How Long Unemployed?</b>	<b>How Long Unemployed?</b>

### 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 or 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			

**TOTAL INCOME:** MONTHLY: \$ YEARLY: \$

<b>EXPENSES</b> (not for outpatient or ER service)	MONTHLY	BALANCE DUE	<b>HOUSEHOLD ASSETS</b> (not for outpatient or ER services)	VALUE
Mortgage or Rent Payment	\$	\$	Savings	\$
Car Payment			Checking	
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 (Auto, Life, Health)			Jewelry & Other Personal Property	
Gas/Transportation			Other Assets (Describe)	
Recreation				
Physicians				
Hospitals				
Other Medical				
Credit Cards				
Other Expenses (Describe)				
			<b>TOTAL HOUSEHOLD ASSETS:</b>	<b>\$</b>
			<b>HOUSEHOLD DEBTS</b>	<b>VALUE</b>
			Home Loan	\$
			Auto Loan	
			Credit Card Debt	
			Other: Total Expenses from "Balance Due" column - (Mortgage + Car Loan + Cr, Cards)	
<b>TOTAL EXPENSES:</b>	<b>\$</b>	<b>\$</b>	<b>TOTAL HOUSEHOLD DEBTS:</b>	<b>\$</b>

**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: