Health System

Financial Statement

Please print and do not leave any lines blank. Print "N/A" in areas that do not apply to your circumstances.

Patient Name: Last	First	MI		
Account Number(s):				
Admission Date(s):	Reason:			
Social Security #:	DOB:	Age:	Male	Female
Marital Status (circle one) Married Common-law married Single Widowed Divorced Separated How long?				
Spouse's Name:	Spouse's Social Security #:			
Patient Home #:	Work #:	Cell #:		
Current Address:				
	Street	City	State	Zip
County:	How long at current address:			
Patient Employer:	Hire Date: (month/day/year)			
If unemployed – last date worked (month/day/year)	Reason:			
Spouse Employer:	Hire Date: (month/day/year)			
If spouse is unemployed – last date worked (month/day/year):	Reason:			

List **ALL** Bank Accounts (Name and Account #s)

Account Name	Account #	Checking	Savings	Other

Property Owned House	Land	Auto (year and make)		
Are you Renting	Buying	Own	Living with and/or supported by someone?	Who?
Number of people living in household:	Relation to you?			
List the ages of **YOUR** children still living in the household:				
Was this an accident?	Nature of accident	Date and place accident occurred		
Have you ever applied for SSI/Social Security Disability?	Date of last SSI application:			
Is the case still open and pending a decision?	If denied, have you filed an appeal?			

Do you have an attorney working on your case?

Attorney Name: Attorney's Phone # and Address:

Health System

Income and Expenses

MONTHLY INCOME

MONTHLY EXPENSES

*If expenses are shared, please list **your** portion only

Income Type	Amount	Expense Type	Amount
Gross wages (patient)		Rent, house, or trailer payment	
Net wages after taxes (patient)		Land/lot payment	
Gross wages (spouse)		Utilities / Gas / Water	
Net wages after taxes (spouse)		Food / Phone Bill	
Gross wages/salary (parents)		Car payment / Car Insurance	
Net wages after taxes (parents)		Car payment / Car Insurance	
*If patient is a child, list income for both parents)		Child support/alimony payment	
Social Security check amount (patient)		Daycare/childcare expense	
Social Security check amount (spouse)		Education/college loans	
Social Security check amount (child)		List all insurance premiums paid:	
SSI Income (list amount & recipient)		Hospital/daily indemnity	
Military/Reserves/VA income		House/renters insurance	
Short/long term disability income		Health insurance	
Child support/alimony received		Student insurance	
Unemployment check amount		Life/burial insurance	
Retirement/pension check amount		Cancer insurance	
Workman's Compensation		Doctor and medical expenses (monthly)	
Rental income received		Prescription costs (out of pocket)	
AFDC/Family Assistance		Credit Card Name:	
Food Stamps received		Credit Card Name:	
Church assistance received		Credit Card Name:	
Other income or money received		Other expense	

Applicant's statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge and that no pertinent items of information have been concealed or omitted from this application. I also understand that Huntsville Hospital has the right to reverse their decision concerning charity discounts when discovery of information is made that indicates the patient/guarantors has or had the ability to pay for their services. I am giving Huntsville Hospital; permission to access my credit file and to provide my financial information to those companies contracted by Huntsville Hospital for the purpose of financial or product recovery programs for which I may qualify. If there is anyone you would like to allow us permission to speak with in regard to completing the financial application process, please list them below as a designated person in the space provided.

DESIGNATED PERSON

PATIENT'S INITIALS TO APPROVE

PATIENT /FAMILY REPRESENTATIVE SIGNATURE

DATE

SPOUSE'S SIGNATURE

DATE

ELIGIBILITY SCREENER

FINANCIAL COUNSELOR