



| Patient Information | | | |
|--|---|-------------------|--|
| Patient Name | Date of Birth | Telephone No. | Patient Number |
| Home Address | Rent <input type="checkbox"/> Own <input type="checkbox"/> | | Live with parents? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| City, State, Zip | Social Security Number | Marital Status | |
| Name and Address of Employer | How Long Employed? | Telephone Number | |
| If Unemployed, Last Date & Place of Employment | Position/Title | Supervisor's Name | |

| Spouse Information | | |
|--|----------------------------|------------------------|
| Name | Date of Birth | Social Security Number |
| Name and Address of Employer | How long employed? | Telephone Number |
| If Unemployed, Last Date & Place of Employment | Position/Title | Supervisor's Name |
| Total Number in Family | Names and Ages of Children | |

| Monthly Income | | | | Assets | |
|------------------------|---|--|--|---|---------------|
| Item | <input type="checkbox"/> Patient <input type="checkbox"/> Spouse | <input type="checkbox"/> Parent <input type="checkbox"/> Spouse | <input type="checkbox"/> Parent <input type="checkbox"/> Spouse | | |
| Net Monthly Income | | | | Checking Account(s) (bank & account #) | Balance |
| Social Security | | | | Savings Account(s) (bank & account #) | Balance |
| Interest/Dividends | | | | Other (bank & acct. #) (money market, CD, IRA) | Balance |
| Rental Income | | | | Life Insurance (company & account #) | Value |
| Alimony/Child Support | | | | Stocks and Bonds (company) | Value |
| Unemployment | | | | Furniture | Value |
| State Assistance | | | | Automobiles/Trucks (make, model, year) | Value |
| Food Stamps | | | | | |
| Pension | | | | | |
| Disability | | | | Other Assets (personal, livestock, machinery, motorcycle, RV, boat) | Value |
| Workman's Compensation | | | | | |
| Other | | | | Real Estate (list and describe) | Present Value |
| Other | | | | | |
| Total | | | | Total Assets: | |

PLEASE COMPLETE THE INFORMATION AS THOROUGHLY AS POSSIBLE SO THAT AN ACCURATE ASSESSMENT OF YOUR CURRENT FINANCIAL SITUATION CAN BE DETERMINED. ALONG WITH THE FINANCIAL STATEMENT, THE FOLLOWING ITEMS ARE REQUIRED FOR REVIEW:

1. Most recently filed federal and state income tax
2. Bank account statement (checking and savings)
3. Verification of income (paycheck stubs, unemployment check, Social Security checks, etc.)
4. Denial form from Department of Public Aid
5. Letter explaining why you are applying for charity

| MONTHLY EXPENSES | | Other Expenses | Monthly Payment | Balance | Payment Current? |
|-----------------------|-------------------------|--|-------------------------------|----------------------|--|
| ITEM | Monthly Payments | Charge Accounts (list) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rent | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mortgage | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cell Phone | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gas/Propane | | | | | |
| Electricity | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Water | | Personal Loan (Name & Purpose) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Refuse | | Automobile Loan (Name) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Telephone | | Real Estate Loan (Name) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cable TV | | Miscellaneous (Name & Purpose) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clothing | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medicine | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Baby Sitter | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alimony/Child Support | | | Total Monthly Payments | Total Balance | |
| Transportation | | Total | | | |
| SUMMARY | | | | | |
| Auto Insurance | | Total Monthly Income: \$ _____ Total Monthly Expenses: \$ _____ Discretionary Income: \$ _____ Monthly Payment Arrangement: \$ _____ | | | |
| Home Insurance | | | | | |
| Life Insurance | | | | | |
| Health Insurance | | | | | |
| Personal Property Tax | | | | | |
| Real Estate Tax | | | | | |
| Subtotal | | | | | |

OTHER INFORMATION

Will the patient be unable to work or go to school due to physical impairment? Yes No

If so, what is the disabling condition or diagnosis? _____

Comments: _____

PATIENT AGREEMENT

The undersigned applies for financial assistance in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The creator will retain the original or a copy of this application, even if financial assistance is not granted. The undersigned also agrees to allow Sparta Community Hospital to contact any or all of the above referenced for credit verification, including credit bureaus.

Patient Signature: _____ Date: _____

Responsible Party or Spouse Signature _____ SCH Representative _____

