Decatur Health Application for Financial Assistance

Patient Name	Social Security #	Medical Record #	Date App Received	Date App Returned

Address	Guarantor (ie. Spouse, Significant Other, Parent, etc)	Relationship
Street:	Name	
	Street	
City, ST, Zip	City, ST, Zip	
Phone #	Phone #	

List all members of the household including age & relationship (use a separate sheet if needed)

Employment

Verification of income on all amounts listed below is required. Please provide documentation such as W2, Paystub, or Letter from Employer

Patient's Employer		Guarantor's Employer	
Address		Address	
Phone #	Monthly Gross Income	Phone #	Monthly Gross Income

Other Monthly Income (ie. SSI, Child Support, Workman's Comp, Unemployment, Pension, Rent, Alimony, etc)

Other Monthly Income Type	Other Monthly Income Type

If you do not have monthly income, please explain how you take care of your monthly expenses

Health Insurance

Do you have health insurance? **Yes** **No**	Have you applied for Medicaid? **Yes** **No** Date Applied:	
If Yes, Name of Insurance	Date Applied:	If Denied, Date:
	Reason for Denial:	

Attach copy of health insurance or Medicaid correspondance of approval or denial

Financial Information

Banking & Investment

Checking Balance $_____

Savings Balance $_____

Certificates of Deposit $_____

Stocks/Bonds/Mutual Funds $_____

Health Savings/Flexible Spending Account $_____

Assets & Liabilities

	Value	Balance Due
Primary Residence	$_____	$_____
Secondary Residence	$_____	$_____
Vehicle #1 Make_____ Year_____	$_____	$_____
Vehicle #2 Make_____ Year_____	$_____	$_____
Vehicle #3 Make_____ Year_____	$_____	$_____

Assets & Liabilities Continued

Other Assets (Including Artwork, Jewelry; Recreational Vehicles, Campers, etc)	Value	Balance Due
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

Self-Employed Include:

Trade Tools/Equipment	$	$
Business Real Estate	$	$
Business Vehicles	$	$

Other Liabilities

Payment To _____ For_____ $_____
Payment To _____ For_____ $_____
Payment To _____ For_____ $_____
Payment To _____ For_____ $_____
Payment To _____ For_____ $_____

Other Pertinent Information Regarding Financial Situation

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any other assistance which may be available for payment of my charges (Medicaid, Insurance, etc.) and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the facility the amount recovered for such charges. I understand that the information given is to be used to ascertain my ability to pay for the services provided by Decatur Health. I hereby grant permission to Decatur Health to investigate the information contained herein.

Patient/Guarantor Signature _____ Date _____

Application Determination **Approved** **Denied** Date Determination Letter Mailed _____

Reason for Denial _____

Hospital Representative Signature(s) _____

_____

Date _____