Patient Legal Name:______________________________ **Date of Birth:**__________ **Social Security#**______________

Mailing Address:______________________________ **City/State:**________________ **Zip Code:**____________

Street Address (if different): ______________________ **City/State:** ________________**Zip Code:** ____________

Home Phone #: ____________________**Cell Phone** #**:** ________________**Business Phone** #**:**______________

Employer: ________________________ **Occupation**: ________________ **Gross** monthly income: $____________

List members of Family Unit: (defined as the applicant, spouse, and all legal dependents as allowed by the Federal Government).

Family Member Names	Birth Date	Sex	Relationship to Patient	Social Security Number	Employer/Hire Date	Gross Monthly Income
						$
						$
						$
						$
						$
						$

Proof of other income sources that you receive monthly:	
Supplemental Security Income (SSI)	$
Social Security Disability (SSDI)	$
Unemployment	$
Food Stamps	$
Welfare (AFDC)	$
Veteran's Benefits (VA) S	$
Pensions/Retirement Benefits	$
Child Support	$
Interest/Dividends on Investments	$
Other income:	$

Assets:	
Savings Account(s)	$
Checking Account(s)	$
Stocks/Bonds (market value)	$
Face Value of Certificate of Deposit(s)	$
Recreational Vehicles (boats, motorcycles, atvs, etc.)	$
Cars/Trucks	$
Other assets:	$

Hospital Use Only
Date of Issued
Issuing Department/Person
Date Recv'd
Recv'd By
MR#

Monthly Expenses:	
Mortgage or Rent:	
1. Mortgage/Rent monthly payment	$
2. Property Taxes/Insurance	$
3. Appraisal Value of home	$
Utilities: (water, garbage, electric, gas)	$
Cable/Satelite, phone, cell phone and pagers	$
Food and Toiletries	$
Total Automobile Payments:	
1. Auto payment	$
2. Second automobile payment	$
3. Auto fuel	$
4. Auto insurance	$
5. Auto repair expense	$
Credit Cards	$
Loans:	$
Insurance Premiums	
1. Life	$
2. Medical	$
Healthcare expenses:	
1. Medical Bills	$
2. Dental Bills	$
3. Prescriptions	$
Child Care Expenses:	$
Other Expenses:	$

I certify that the Information given on this form is true and complete to the best of my knowledge and that it is for the purpose of evaluating my financial condition and ability to pay any bills or charges for hospital services that I have received from Union General Hospital or any accounts which I have signed as Guarantor. I authorize my employer to release information regarding my income which may be necessary In evaluating my financial needs. I agree to promptly notify Union General Hospital of any changes in financial status affecting my ability to pay. By requesting financial assistance, I understand Union General Hospital may inquire Into my (our) credit history.

Signature: ______________________________________**Date:**____________________

Signature of Spouse:__________________________________ **Date:**____________________

(If married spouse signature required)