Personal Financial Statement for Financial Assistance

Patient Name	Age:	Phone Number	Marital Status S M W D	Social Security Number

Date Pt. Received:	Acct. #/Balance: /$
Please Return By:	Acct. #/Balance: /$
Date Returned:	Acct. #/Balance: /$

Patient		**Person Responsible for Bill (If not the Patient)**	**Relationship**
Address		Name:	
City, State, Zip		Street:	
Phone: ( )	Cell: ( )	Phone: ( )	Cell: ( )

EMPLOYMENT	
Patient's Employer:	Guarantor's Employer:
Occupation:	Occupation:
If unemployed, Name of Last Employer:	If unemployed, Name of Last Employer:
How Long Unemployed:	How Long Unemployed:

LIST BELOW ALL MEMBERS OF THE HOUSEHOLD BEGINNING WITH THE PATIENT			
Name:	Age:	Relationships	

Do You have Health Insurance coverage available? YES NO

If yes, why is it not available for this date of service?

If no, please indicate the reason for lack of insurance coverage:
Insurance cost is too high? Yes or No
Pre-existing condition? Yes or No
Other, Please Describe:

Have you applied for Medicaid? YES NO
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			
Disability Payments			
Dividends/Interest			
Other, List			
MONTHLY INCOME SUBTOTAL			
TOATL INCOME:	**MONTHLY : $**		**YEARLY: $**

EXPENSES	**MONTHLY**	**BALANCE DUE**	
Mortgage or Rent Payment			
Car Payment			
Utilities (Gas, Electric, Water)			
Cable			
Phone (Including Cell)			
Food			
Child Care			
Clothing			
Insurance (Auto, Health, Life)			
Gas/Transportation			
Recreation			
Physicians			
Hospitals			
Other Medical			
Credit Cards			
Other Expenses (describe)			
TOTAL EXPENSES:	**$**	**$**	

OTHER PERTINENT INFORMATION REGARDING FINACIAL SITUATION

I VERIFY THE INFORMATION PROVIDED IS CORRECT AND COMPLETELE. I AUTHORIZE VERIFICATION OF NAY INFORMATION AND UNDERTSTAND THAT ADDITONAL DOCUMENTAION MAY BE REQUETED. IF ANY INFORMATION IS FOUND TO BE FALSE, FINANCIAL ARRAGMENTS OR ASSITANCE MAY BE VOIDED

Patient/Responsible Party Signature:	Date:
Application Determination: APPROVED/DENIED	Date Determination Letter Mailed:
Reason For Denial:	
Hospital Representative Signature(s):	

SMITH COUNTY
MEMORIAL HOSPITAL

Financial Assistance Application Instructions

1. Complete the financial assistance application within 10 days of receipt.
2. Return the completed application to Smith County Memorial Hospital with a copy of the previous year's income tax return or copies of six months of pay stubs as proof of income.
3. SCMH's Financial Counselor will review the application and issue a qualification status letter within two weeks. If the applicant has not met qualification requirements, a denial will be issued with a reason for the decision.