ARTESIA

Artesia General Hospital

Financial Information Form

_____ _____
Print Patient Name Account No. or Social Security No.

Instructions: All questions must be answered. If a question does not pertain, write N/A on the line. Attach a photocopy of one of the following proofs of income to the completed form:

1. Last years tax return statement
2. Social Security check or award letter
3. Last 2 paycheck stubs
4. Unemployment or Food Stamp award letter
5. Letter from employer – on letterhead (to include employee name, hourly wage, number of hours worked)

Citizenship (check one): _____U.S. Citizen_____Non-US Citizen

Marital Status (check one): _____Married _____Single _____Divorced _____Seperated

Names of Dependents (legal deductions on your tax return) Number in household_____

Name:_____Relationship_____Date of Birth_____
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Name:_____Relationship_____Date of Birth_____

Housing (check one) _____Own _____Rent _____Paid House Payment $_____/month
Utilities Electricity $_____/month Gas $_____/month Water $_____/month

Automobiles Own (How many?)_____Lease (How many?)_____ Car Payment(s): $_____/month

Bank Accounts/Other Assets **(must answer all three questions)**

Checking Account? Yes No $_____ Savings Account? Yes No _____

Additional Assets? (Circle one) Yes No Describe_____

Employment-PATIENT-_____Name of Employer:_____

Employment-SPOUSE/GUARNTOR – Name of Employer:_____

Patient
____ Employed Full Time
____ Employed Part Time
____ Not Employed

Spouse/Guarantor
_____ Employed Full Time
_____ Employed Part Time
_____ Not Employed

Other Support
Alimony $_____per month
Trust Fund $_____per month
Unemployment $_____per month
Child Support $_____per month
Survivors Benefit $_____per month
Workman's Comp $_____per month

Total Family Income $_____per month **(Award requires proof of income with application)**

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patient's family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. I understand this determination is conditional and does not apply to third party claims such as lawsuits, settlements, hospital liens, or any other third party payment or liability. Artesia General Hospital retains its rights to recover the full balance of my bill from any third party resource to the fullest extent allowed by law. If my (our) case is selected for Indigent Care classification, I (we) give my (our) consent to Artesia General Hospital to obtain information from any source to verify the statements I (we) have made.

_____ _____
Patient / Guarantor Signature Date

_____ Approved _____Denied

_____ _____
Administrative Signature Date