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________________
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/GUARANTOR – 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

_______________________________ Administrative Signature

_______________ Date

COPY OF MEDICAID DENIAL LETTER MUST BE ATTACHED TO APPLICATION