

Harlan County Health System Personal Financial Statement for Financial Assistance

Patient Name       Age       Phone Number       Marrial Status S M W D       Social Security #         Street:       Name:       Retationship:         Street:       Name:       Retationship:         Gity, State, Zip       Street:       Street:         Phone: (_)       Cell: (_)       Cell: (_)         Patient's Employer:       Cell: (_)       Cell: (_)         Patient's Employer:       Gearantor's Employer:       Cell: (_)         Occupation:       If Unemployed, Name of Last Employer:       Occupation:         How Long Unemployed?       How Long Unemployed, Name of Last Employer:       If Unemployed, Name of Last Employer:         Name:       Kist all members of your houseHold beginning with the Patient.       Relationship         List all members of your houseHold beginning with the Patient.       Image: Street	Demographic Information							
Street:     Name:     Relationship:       Street:     Street:       City, State, Zip     City, State, Zip       Phone: ( )     Cell: ( )       Cocupation:     Guarantor's Employer:       Occupation:     Occupation:       If Unemployed, Name of Last Employer     If Unemployed, Name of Last Employer       How Long Unemployed?     How Long Unemployed?       Household Members     Isst all members of your household beginning with the Patient.       Name     Age       Name     Age       Name     Age       Name     Age       Insurance Coverage Information     Insurance       Do you have health insurance coverage available?     Yes       If yes, why was it not available for this date of service?	Patient Name	Age	Phone Number		Social Security #			
Street:     Street:       City, State, Zip     Phone: ( )     Cell: ( )       Phone: ( )     Cell: ( )     Cell: ( )       Patient's Employer:     Guarantor's Employer:     Guarantor's Employer:       Occupation:     If Unemployed, Name of Last Employer     Gocupation:       If Unemployed, Name of Last Employer     If Unemployed, Name of Last Employer     How Long Unemployed?       How Long Unemployed?     How Long Unemployed?     How Long Unemployed?       Name     Age     Relationship       Age     Relationship     Image: Comparison of Comparison	Patient							
City, State, Zip     City, State, Zip       Phone: (_)     Cell: (_)       Phone: (_)     Cell: (_)       Phone: (_)     Cell: (_)       Patient's Employer:     Gaarantor's Employer:       Occupation:     Occupation:       If Unemployed, Name of Last Employer     If Unemployed, Name of Last Employer       How Long Unemployed?     How Long Unemployed?       Household Members     It was household beginning with the Patient.       Name     Age       Relationship     Relationship       Image: State Relationship     Image: State Relationship       Image: State Relation Relation Relation     Image: State Relation Relatin Relation Relation Relation Relation Relation Relatin Relation Re	Street:			Name: Re				
Phone: ( )     Cell: ( )     Phone: ( )     Cell: ( )       Patient's Employeer:     Guarantor's Employeer:     Guarantor's Employer:       Occupation:     Occupation:     Occupation:       If Unemployed, Name of Last Employer     If Unemployed, Name of Last Employer     If Unemployed, Name of Last Employer       How Long Unemployed?     How Long Unemployed?     How Long Unemployed?       Household Members       List all members of your household beginning with the Patient.       Name     Age     Relationship       Age     Relationship     Image: Colspan="2">Colspan="2"       Mame     Age     Relationship     Image: Colspan="2"				Street:				
Phone: ( )     Cell: ( )     Phone: ( )     Cell: ( )       Patient's Employeer:     Guarantor's Employeer:     Guarantor's Employer:       Occupation:     Occupation:     Occupation:       If Unemployed, Name of Last Employer     If Unemployed, Name of Last Employer     If Unemployed, Name of Last Employer       How Long Unemployed?     How Long Unemployed?     How Long Unemployed?       Household Members       List all members of your household beginning with the Patient.       Name     Age     Relationship       Age     Relationship     Image: Colspan="2">Colspan="2"       Mame     Age     Relationship     Image: Colspan="2"								
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Employment information       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?       Household Members       List all members of your household beginning with the Patient.       Name     Age       Relationship     If       Insurance Coverage Information     If       Do you have health insurance coverage available?     Yes       If yes, why was it not available for this date of service?     If       If no, indicate the reasoning for lack of coverage:     Insurance Condition       Insurance Cost too High     Pre-Existing Condition     If       Have you applied for Medicaid?     Yes     Date Applied:	City, State, Zip			City, State, Zip				
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?       Household Members       List all members of your household beginning with the Patient.       Name     Age       Relationship     Image: Colspan="2">Colspan="2"       How Long Unemployed?     How Long Unemployed?     Relationship     Colspan="2"       Name     Age     Relationship     Colspan="2"	Phone: ( ) Cel	l: ( )		Phone: ( )	Cell: ( )			
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Name   Age   Relationship     Image: Name   Age   Relationship     Image: Name   Image: Name   Image: Name     Image: Name   Image: Name   Image: Name <								
Image: state of the set		List all me	mbers of your househ	old beginning with the Pa				
Do you have health insurance coverage available?     Yes No       If yes, why was it not available for this date of service?	Name			Age	Relationship			
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If yes, why was it not available for this date of service?	Do you have health incurrence an	uoro concil						
If no, indicate the reasoning for lack of coverage:       Insurance Cost too High        Other (please describe)        Have you applied for Medicaid?     Yes     No       Date Applied:	you have health insurance co	verage availa	able !	1 es No	)			
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Insurance Cost too High Other (please describe)     Pre-Existing Condition       Have you applied for Medicaid?     Yes       No     Date Applied:								
Insurance Cost too High Other (please describe)     Pre-Existing Condition       Have you applied for Medicaid?     Yes       No     Date Applied:								
Other (please describe)	If no, indicate the reasoning for	ack of cover	age:					
Have you applied for Medicaid? Yes No Date Applied:			Pre-Existing	Condition				
	Other (please describe)							
		V	NT.		1. 1			
If denied date of denial: Reason for Denial:	Have you applied for Medicaid?	Yes	No	Date App	bilea:			
	If denied, date of denial		Reason for Denial					
*If denied, please attach a copy of the Medicaid Denial Letter to this application.								

			<b>nthly Income Informat</b> h Copies of Proof of Inc		
		Patient	Spouse		Other Household Member (18+)
Wages (Gross)		\$	\$	\$	
Social Security		\$	\$	\$	
Pensions		\$	\$	\$	
Unemployment/Workers	Comp	\$	\$	\$	
Alimony/Child Support		\$	\$	\$	
Government Assistance		\$	\$	\$	
Disability Benefit Payme	nts	\$	\$	\$	
Dividends/Interest		\$	\$	\$	
Other (specify)		\$	\$	\$	
Monthly Income Subtot	al	\$	\$	\$	
<b>Total Income</b> (monthly)		\$	\$	\$	
Total Income (annually)		\$	\$	\$	
		Exp	ense & Asset Informat	tion	
Expenses	Monthly	Balance Due	Household Assets		Value
Mortgage/Rent	\$	\$	Savings		\$
Car Payment	\$	\$	Checking		\$
Utilities	\$	\$	Stocks & Bonds		\$
Cable	\$	\$	Mutual Funds		\$
Phone (including Cell)	\$	\$	Value of Life Insurance	ce	\$
Food	\$	\$	Real Estate Value		\$
Child Care	\$	\$	Farm Real Estate Valu	ıe	\$
Clothing	\$	\$	Vehicle Value (non-prin	mary)	\$
Insurance (auto,life,health)	\$	\$	Jewelry/Personal Prop	berty	\$
Gas/Transportation	\$	\$	Other Assets		\$
Recreation	\$	\$	<b>Total Assets</b>		\$
Physicians	\$	\$	-		
Hospitals	\$	\$	Household Debts		Value
Other Medical	\$	\$	Home Loan		
Credit Cards	\$	\$	Auto Loan		\$
Other Expense	\$	\$	Credit Card Debt		\$
Other Expense	\$	\$	Other		\$
Total Expenses	\$	\$	Total Debts		\$
	Oth	er Pertinent In	formation Regarding I	Financi	al Situation

I verify the information provided is correct and complete. I authorize verification of any information and understand that additional documentation may be requested. If any information is found to be false, financial arrangement or assistance may be voided.

Date:

Internal Use Only					
Application Determination: Reason for Denial:	Approved / Denied	Date Determination Letter Sent:			
Hospital Representative Signa	ture(s):	Date:			