Harlan County Health System

Personal Financial Statement for Financial Assistance

Demographic Information				
Patient Name	Age	Phone Number	Marital Status S M W D	Social Security #

Patient		**Guarantor** (if not patient)	
Street:		Name:	Relationship:
		Street:	
City, State, Zip		City, State, Zip	
Phone: ( )	Cell: ( )	Phone: ( )	Cell: ( )

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

Insurance Coverage Information

Do you have health insurance coverage available? Yes_____ No_____

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

_____

If no, indicate the reasoning for lack of coverage:
Insurance Cost too High _____ Pre-Existing Condition _____
Other (please describe) _____

Have you applied for Medicaid? Yes_____ No_____ Date Applied: _____

If denied, date of denial: _____ Reason for Denial: _____
**If denied, please attach a copy of the Medicaid Denial Letter to this application.*

Monthly Income Information

Attach Copies of Proof of Income.

	Patient	Spouse	Other Household Member (18+)
Wages (Gross)	$	$	$
Social Security	$	$	$
Pensions	$	$	$
Unemployment/Workers Comp	$	$	$
Alimony/Child Support	$	$	$
Government Assistance	$	$	$
Disability Benefit Payments	$	$	$
Dividends/Interest	$	$	$
Other (specify) _____	$	$	$
Monthly Income Subtotal	**$**	**$**	**$**
Total Income (monthly)	**$**	**$**	**$**
Total Income (annually)	**$**	**$**	**$**

Expense & Asset Information

Expenses	Monthly	Balance Due
Mortgage/Rent	$	$
Car Payment	$	$
Utilities	$	$
Cable	$	$
Phone (including Cell)	$	$
Food	$	$
Child Care	$	$
Clothing	$	$
Insurance (auto,life,health)	$	$
Gas/Transportation	$	$
Recreation	$	$
Physicians	$	$
Hospitals	$	$
Other Medical	$	$
Credit Cards	$	$
Other Expense	$	$
Other Expense	$	$
Total Expenses	**$**	**$**

Household Assets	Value
Savings	$
Checking	$
Stocks & Bonds	$
Mutual Funds	$
Value of Life Insurance	$
Real Estate Value	$
Farm Real Estate Value	$
Vehicle Value (non-primary)	$
Jewelry/Personal Property	$
Other Assets	$
Total Assets	**$**

Household Debts	Value
Home Loan	
Auto Loan	$
Credit Card Debt	$
Other	$
Total Debts	**$**

Other Pertinent Information Regarding Financial 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.

Patient/Responsible Party Signature: _____ Date: _____

Internal Use Only

Application Determination: Approved / Denied Date Determination Letter Sent: _____

Reason for Denial: _____

Hospital Representative Signature(s): _____ Date: _____