( ) Broaddus Hospital ( ) Davis Memorial Hospital ( ) Webster Memorial Hospital

Applicant Information

Name: _____ Application Date: _____

Address: _____ Birth Date: _____

Employer: _____ Phone #: _____

Household Information

List each family member(s) living with you:

Name	**Relationship**	**Age**	**Sex**	**Employer**

Income Information

Provide photocopies of checks and list income for the family from:	Monthly	Annual
Wages: Self……..	$	$
Spouse…….	$	$
Other Family Member…….	$	$
Farm or self-employment……..	$	$
Public Assistance……...	$	$
Unemployment Compensation……..	$	$
Social Security……...	$	$
Strike Benefits……...	$	$
Alimony…….	$	$
Child Support……	$	$
Military Family Allotments……...	$	$
Pensions…….	$	$
Income from Dividends, Interest, Rent…….	$	$

If none, how are your housing, food and transportation expenses met? _____

Expenses

List all household credit cards or other commercial accounts (e.g. VISA, MasterCard, American Express, department store accounts, student loans, etc.

Name of Creditor	Current Balance	Monthly Payment
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	Subtotal:	$

List all other monthly household living expenses.

	Monthly Payment		Monthly Payment
Mortgage	$_____	Gasoline or other Transportation	$_____
Tax Value $_____	$_____	Child Care	$_____
Mortgage Balance$_____	$_____	Insurance (Home, Car, Health, Life)	$_____
Car Payments	$_____	Taxes	$_____
Make(s)/Model(s)_____	$_____	Medications	$_____
Year(s)_____	$_____	Other	$_____
Food	$_____	Other	$_____
Utilities	$_____	Total Expenses:	$_____

Does your household have checking account(s)? ( )Yes ( ) No If yes, Balance $_____
Does your household have savings account(s)? ( )Yes ( ) No If yes, Balance $_____
Does your house hold have Certificates of Deposit, IRA's, Mutual Funds, Stocks, Bonds, etc.? ( )Yes ( ) No If yes, Balance $_____

Please check that you have provided: ( ) Previous year's tax returns ( ) Income verification showing year to date earnings or pay stubs for the last 3 months

- I hereby certify the information contained in the above financial questionnaire is correct and complete to the best of my knowledge.
- I understand that Davis Health System may verify the above information.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by DHS or I may appeal in writing with additional documentation.

_____ _____
Signature **Date**

FOR HOSPITAL USE ONLY: Amount Owed Davis Health System

_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____

Total Family Income $_____ Total Family Expenses $_____
Fed Poverty Guidelines $_____ Total Disposable Income $_____

( ) **Approved**
Total Amount to be Paid by the Patient $_____
Total Amount of Financial Aid $_____

( ) **Denied**
( ) Excess Assets
( ) Excess Income
( ) Failure to prove income
( ) Incomplete Application
( ) Medicaid Eligibility

Credit Representative: _____ **Date:** _____
Patient Accounts Manager: _____ **Date:** _____
Chief Financial Officer: _____ **Date:** _____