



Financial Disclosure Application
(BOTH PAGES MUST BE COMPLETED BY PATIENT/APPLICANT)

- Tyrone Hospital Tyrone RHC Houtzdale RHC ProCare Tyrone
 Bellemeade Family Medicine Pincroft We Care

Date of Application: _____

PATIENT / GUARANTOR INFORMATION:

Last Name: _____ First Name: _____ M.I. _____ S.S. # _____ DOB: _____

Mailing Address: _____ Phone: _____ Cell: _____

Is Patient / Guardian actively employed? _____ Retired? _____ Disabled? _____ Employer: _____

How Long? _____ Occupation: _____

SPOUSE OR SIGNIFICANT OTHER INFORMATION:

Last Name: _____ First Name: _____ M.I. _____ S.S. # _____ DOB: _____

Is Patient / Guardian actively employed? _____ Retired? _____ Disabled? _____ Employer: _____

How Long? _____ Occupation: _____

Source of income for dependent / household member: _____ Person: _____

Total Number of Dependents / Household Members: _____

Names of All Dependents / Household Members:

Name: _____ Age: _____ S.S.# _____ DOB: _____ Relationship: _____

Name: _____ Age: _____ S.S.# _____ DOB: _____ Relationship: _____

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Name: _____ Age: _____ S.S.# _____ DOB: _____ Relationship: _____

Name: _____ Age: _____ S.S.# _____ DOB: _____ Relationship: _____

Are any Family / Household Members covered by Medicaid? _____ Food Stamps/GA/Fuel Asst? _____ How Much? _____

Have you Applied for Medicaid? _____ When? _____ Note: A Copy of the "Notice of Decision is required for Consideration

REAL ESTATE / PROPERTY INFORMATION:

Do You Rent? _____ Own? _____ : House _____ Mobile Home _____ Farm _____ Camp _____ Acreage _____ Value \$ _____

Other (Describe): _____ Mortgage Holder(s): _____

HOUSEHOLD ASSET INFORMATION:

How Many Vehicles in Your Household? _____ Describe Year(s) and Make(s): _____

Do You Own Other Recreational Vehicles (Boats, Snowmobiles, RV, Campers, Four Wheelers, Motorcycles, Off-Road Vehicles, ETC)?
YES: _____ NO: _____

If Yes, Describe: _____

Checking Account(s) _____ \$ _____ Bank: _____ Location: _____

Savings Account(s) _____ \$ _____ Bank: _____ Location: _____

CD's \$ _____ Mutual Funds \$ _____ Stocks/ Bonds \$ _____

MONTHLY HOUSEHOLD INCOME:

Gross Wages	\$ _____/Month	Child Support	\$ _____/Month
Pensions	\$ _____/Month	Unemployment	\$ _____/Month
Social Security	\$ _____/Month	Food Stamps	\$ _____/Month
W/Comp	\$ _____/Month	Interests/Dividends	\$ _____/Month
Rental	\$ _____/Month	Other	\$ _____/Month

ESTIMATED MONTHLY EXPENSES:

Mortgage/Rent	\$ _____/Month	Loan/Lease	\$ _____/Month
Water/Electric	\$ _____/Month	Credit Cards	\$ _____/Month
Fuel (Heat)	\$ _____/Month	Home/Auto Insurance	\$ _____/Month
Prescriptions	\$ _____/Month	Medical/Dental Bills	\$ _____/Month
Property Tax(s)	\$ _____/Month		
Other Expense	\$ _____/Month	Describe:	_____

PLEASE STATE BRIEFLY IN YOUR OWN WORDS WHY PAYMENT OF A TYRONE HOSPITAL BILL(S) WILL PRESENT A FINANCIAL HARDSHIP TO YOU AND YOUR FAMILY:

I AM REQUESTING FINANCIAL ASSISTANCE WITH TYRONE HOSPITAL. I CERTIFY ALL OF THE INFORMATION PROVIDED BY ME IN THIS FINANCIAL AID PACKET IS TRUE AND ACCURATE. TYRONE HOSPITAL HAS MY PERMISSION TO PURSUE ANY AREA FOR VERIFICATION OF PERTINANT INFORMATION AND I AUTHORIZE ACCESS TO MY CREDIT FILE TO VERIFY CREDIT HISTORY. **BASED ON FINANCIAL ASSISTANCE CARE POLICY APPLICATIONS IN SELFPAY STATUS LONGER THAN 120 DAYS THAT HAVE WENT INTO COLLECTIONS STATUS WILL NOT BE CONSIDERED FOR FINANCIAL ASSISTANCE.**

Signature of Patient/Guarantor: _____ Date: _____
(Parent of a minor)

Signature of Spouse: _____ Date: _____
(Both Husband and Wife must sign this form)