TYRONE REGIONAL HEALTH NETWORK

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

☐Tyrone Hospital ☐Tyrone RHC ☐Houtzdale RHC ☐Apex Physical Therapy (Tyrone)

☐Pinecroft Medical Center

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:**_____

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

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

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)