TYRONE HOSPITAL
YOUR HEALTH.OUR CARE.

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

Date of Application: _____

PATIENT INFORMATION:

Last Name: _____First Name: _____S.S.#: _____DOB: _____

Mailing Address: _____Phone: _____Cell: _____
_____

PERSON RESPONSIBLE FOR THE BILL (PARENT IF THE PATIENT IS A MINOR):

Last Name:_____First Name: _____S.S. #: _____DOB: _____

Mailing Address: _____ Phone: _____

Actively Employed? _____Retired? _____Disabled? _____Employer: _____How Long? _____

Occupation: _____

SPOUSE OR SIGNIFICANT OTHER INFORMATION:

Last Name: _____First Name: _____MI: ____S.S.#: _____DOB: _____

Is Spouse/Partner employed? _____Retired? _____Disabled? _____Employer: _____How Long? _____

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

Occupation: _____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 $ _____

ESTIMATED HOUSEHOLD INCOME:

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

ESTIMATED 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)	**$ _____/Year**		
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.

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

Signature of Spouse: _____ Date: _____
(Both husband and wife must sign this form)