



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

- Tyrone Hospital    Tyrone RHC    Houtzdale RHC    ProCare Tyrone  
Bellemeade Family Medicine Pinecroft    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: \_\_\_\_\_

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 SELF-PAY 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)