Health System

Huntsville Hospital
Huntsville Hospital for Women & Children
Madison Hospital
Decatur Morgan Hospital
Helen Keller Hospital
Red Bay Hospital
Athens-Limestone Hospital

(*Please print & do not leave any lines blank. Print "N/A" in areas that do not apply to your circumstances).

Patient Name: Last_____ First _____MI_____

Account Number(s): _____

Admission Date(s): _____ Reason: _____

Social Security #: _____Date of birth_____Age_____Male____Female____

Marital status: *(circle one)* married common-law-married single widowed divorced separated How long? _____

Spouse's name: _____ Spouse's DOB: _____

Spouse's social security# _____

Patient Home #:_____ Work #:_____ Cell #:_____

Current address_____
(Street) (City) (State) (Zip code)
County: _____How long at current address? _____

Name & Phone # of relative not living in your household: _____

Patient Employer: _____ Hire Date: M/D/Y_____

If unemployed –last date worked :_____M/D/Y Reason? _____

Spouse's Employer: _____ Hire Date: M/D/Y _____

If unemployed –last date worked_____ M/D/Y Reason? _____

List ***ALL*** Bank Accounts (include name & acct #):
Patient's Acct: _____ checking_____savings_____other_____
Spouse's Acct: _____ checking_____savings_____other_____
Minor Children's Acct(s) _____ checking_____savings_____other_____

Property Owned: House_____ Land_____ Auto (year & make) _____

Are you? Renting ____ Buying ____ Own_____ Living with/and or supported by someone? _____who_____

Number of people living in the household_____ How are they related to you? _____

List the ages of **<u>your</u>** minor children still living in the household: _____

Was this an accident? _____Nature of accident: _____ Date & Place of accident_____
If involved list:
Medical pay policy ins info _____Liability policy ins info_____

Have you ever applied for SSI/Social Security Disability? _____ Is the case still open and pending a decision? _____

Do you have an attorney working on your case? _____ Attorney Name: _____

INCOME AND EXPENSES

MONTHLY INCOME

Gross wages/employment **(**patient**)** _____

Net wages after taxes (patient) _____

Gross wages/empl (**spouse**) _____

Net wages after taxes (spouse) _____

Gross wages/salary **(parents**) _____

Net wages after taxes (parents) _____

(If patient is a child-please list income for both parents)

Social Security check amt (**patien**t) _____

Social Security check amt (**spouse**) _____

Social Security check amt (**child**) _____

SSI Income **(list amt & whom is receiving)** _____

Military, Reserves, VA income _____

Short/long term disability income _____

Child support/alimony received _____

Unemployment check amount_____ _

Retirement/pension check amt_____

Workman's Compensation_____

Rental income received _____

AFDC/Family Assistance_____

Food Stamps received_____

Church assistance received_____ _____

Other income/$ received_____

MONTHLY EXPENSES

If expenses are shared, please list **your portion only**

Rent or House/Trailer payment _____

Land/lot payment _____

Utilities _____Gas _____Water_____

Food_____ Phone bill amt _____

Car payment _____Car Insurance _____

Car payment _____Car Insurance _____

Child support/alimony payment _____

Daycare/childcare expense _____

Education/college loans_____

List all insurance premiums paid:

Hospital/daily indemnity _____

House/renters insurance_____

Health ins: _____Student ins: _____

Life/burial ins: _____ Cancer ins: _____

Doctor & medical expenses_____

(Monthly payments)

_____

Prescription costs_____

(Out of pocket)

Credit Card Name: _____ pmt_____

Credit Card Name_____ pmt_____

Bank loan Name: _____ pmt_____

Other expense: _____ pmt_____

Applicant's statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge & that no pertinent items of information have been concealed or omitted from this application. I also understand that Huntsville Hospital Health System has the right to reverse their decision concerning charity discounts when discovery of information is made that indicates the patient/guarantor has or had the ability to pay for their services. I am giving Huntsville Hospital Health System permission to access my credit file and to provide my financial information to those companies contracted by Huntsville Hospital Health System for the purpose of financial or product recovery programs for which I may qualify. If there is anyone you would like to allow us permission to speak with in regard to completing the financial application process, please list them below as a designated person in the space provided.

Designated Person: _____ **Patient's Initials to approve** _____

Patient (or family rep) SIGNATURE_____ **Date**_____

SPOUSE'S SIGNATURE_____ **Date** _____

Bolder Rep:_____ **Financial Counselor:** _____