Health System

Huntsville Hospital
Huntsville Hospital for Women & Children
Madison Hosptial
Decatur Morgan Hospital
Helen Keller Hospital
Red Bay 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 has the right to reverse their decision concerning charity discounts when discovery of information is made that indicates the patient/guarantors has or had the ability to pay for their services. I am giving Huntsville Hospital; permission to access my credit file and to provide my financial information to those companies contracted by Huntsville Hospital 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.

Dessignated Person: _____Patient's Initials to approve _____

Patient (or family rep)SIGNATURE_____Date_____

SPOUSE'S SIGNATURE_____Date _____

Medassist Rep:_____Financial Counselor: _____