

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 **your** 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 (patient) _____
 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: _____