

Healthcare Assistance Application

Name: _____ Date of Birth: _____

Address: _____ City State _____ Zip: _____

Phone Number: _____ Social Security Number: _____

FAMILY MEMBERS LIVING IN THE HOUSEHOLD:

Dependant Name	Birth Date	Relationship	Social Security Number

*If more attach sheet

SPOUSE/OR OTHER INCOME:

Employer Name: _____

Address: _____

City, State, Zip _____

Salary: (Gross Monthly) _____

PATIENT INCOME:

Employer Name: _____

Address: _____

City, State, Zip _____

Salary (Gross Monthly) _____

Other Income	Patient's Monthly Income	Spouse/Other Dependent
Social Security/Pensions/Annuities	\$	\$
Unemployment or Workmen's Comp Benefits	\$	\$
Interest/Dividend Income	\$	\$
Child Support/Alimony	\$	\$
Veteran's Benefit	\$	\$
Rental Income	\$	\$
Other	\$	\$

ASSETS:

Real Estate: Own _____ Rent _____		Bank: Name/Address
Market Value:	\$	Bank: Checking
Amount Owed:	\$	Savings
Auto/Truck/Type:		IRA/ Tax Sheltered Annuities
Market Value:	\$	Life Insurance:
Motorcycles, Boats, Campers, Etc.:		Money Market:
Market Value:	\$	Stocks, Bonds, CD's
		Rental Property Owned:
		Business Property Owned:
		Other:

MONTHLY EXPENSES

Rent or House Payments:	\$	Medical Insurance:	\$
Electric, Propane, Oil:	\$	Life Insurance:	\$
Water/Sewer:	\$	Other Medical Bills:	\$
Trash:	\$	Entertainment:	\$
Telephone:	\$	Auto Insurance: (Annual) \$	\$
Mobile Telephone:	\$	Property Tax: (Annual) \$	\$
Child Care:	\$	Other Loans:	\$
Food and Supplies:	\$	Misc. (Specify _____)	\$
Auto Payments:	\$		\$
TV, Cable, Dish, etc.:	\$		\$
Credit Card:	\$	Total Monthly Expenses:	\$

I/We do hereby certify that the information provided above is accurate and a true representation of my/our financial information. I/We understand that this application must be completed and returned to the Financial Counselor within 90 days of discharge for self pay patients. For patient's covered by insurance the application must be received within 90 days from the date of payment or valid denial. I/We understand that insurance payment or valid denial and completion of this application does not relieve me/us of the financial obligations to Ferrell Hospital. I/We also understand that the falsification of any information submitted with this application will result in denial of application. I/We agree to provide the necessary verification of my/our income and authorize Ferrell Hospital to make all inquires that Ferrell Hospital deems necessary to verify the accuracy of the statements made herein, including but not limited to procuring a credit report from the credit bureau and/or other financial institutions. Ferrell Hospital reserves the right to deny any application upon their review.

Date: _____ Signed: _____

Date: _____ Signed: _____

EMPLOYEE WAGE FORM (To Be Completed And Signed By Employer)

Employee Name: _____ Employee Social Security Number: _____
Employer Name: _____ Telephone _____ Ext. _____
Address: _____ City, State, Zip _____

WAGES FOR THE LAST 90 DAYS OR 3 MONTHS

WEEK	PAY PERIOD ENDING	GROSS WAGES
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

1. Is the employee currently working? _____ (yes/no), If no, when was the last day worked? _____

2. If the employee is not currently working, will the employee be returning to work? _____ (yes/no)

Expected return date _____

I certify the wage information regarding the person named above is true and accurate.

Date: _____ Signed: _____

Signature of Employer or Employer's Representative

PATIENT FINANCIAL HELP FORM

This statement is to be completed and signed by the person helping you with your living and financial expenses.

Name: _____

Address: _____

Phone Number: _____

Relationship of Person to You: _____

What assistance is currently being provided (check all that apply)?

_____ Shelter _____ Food _____ Financial Assistance

Other Assistance Provided: _____

Estimated dollar amount provided in the last 30 days _____.

Signature of Person Providing Help:

Date:



1201 Pine Street
Eldorado, IL 62930
Phone: (618)-273-3361
Fax: (618)-273-2571

LINK CARD VERIFICATION

PATIENT NAME _____

CARD HOLDER NAME _____

ADDRESS _____

PHONE NUMBER _____

LINK CARD AMOUNT _____

EXPIRATION DATE _____

SIGNATURE OF CARD HOLDER _____

DATE _____