Stanislaus Surgical Hospital

FINANCIAL STATEMENT FOR CHARITY CARE

Name of Applicant	Applicant's SS # __________ Co-Applicant's SS # __________
Name of Co-Applicant / Home Phone # ( )	Date of Birth: Applicant ________ Co-Applicant ________ Children ________ Other ________
Address	Work Phone #: Applicant ________ Co-Applicant ________

Optional: You do not have to answer, but it may aid in qualifying you for a federal or state assistance program such as Medi-Cal or Disability.

Are you pregnant? Y or N   Are you disabled? Y or N

Do you have children? Y or N   If yes, how many? ______

PART 1 - PLANNED EXPENSES and PAYMENTS

A - CASH EXPENSES	***MONTHLY***	***NEXT 12 MO.***	***TOTAL BAL. DUE***
FOOD			
CLOTHING			
MEDICAL: (**List names of clinics and hospitals**)			
Clinic			
Clinic			
Hospital			
Hospital			
Dentist			
Drugs			
Other			
PERSONAL:			
Toiletry, Cosmetics			
Beauty, Barber			
Laundry, Cleaning			
Allowances, Lunches			
Subscriptions			
Cash			
Other			
HOUSEHOLD:			
House Payments / Rent			
Fuel			
Electricity			
Telephone			
Cable TV			
Water and/or Sewer			
Other			
HOME REPAIR and MAINTENANCE:			

EDUCATION: (Tuition, Books, Fees, etc.)			
A - CASH EXPENSES (continued)	***MONTHLY***	***NEXT 12 MO.***	***TOTAL BAL. DUE***
GIFTS: (Holidays, Birthdays, Charity, Church, etc.)			
RECREATION:			
Eating Out			
Vacation & Trips			
Babysitters			
Activities			
Other			
VEHICLES:			
Payment 1: Year Make Model Loan #			
Payment 2: Year Make Model Loan #			
Gas & Oil			
Insurance			
License			
Maintenance & Repair			
TRANSPORTATION: (Bus, Taxi, Train, etc.)			
INSURANCE:			
Health			
Dental			
Life			
Other			
TAXES PAYABLE: (taxes you pay in for the month/year)			
Income			
Social Security			
Other			
UNION or PROFESSIONAL DUES			
CHILD CARE			
CHILD SUPPORT / ALIMONY (PAID OUT)			
PLANNED CASH PURCHASES			
OTHER:			
A. TOTAL CASH EXPENSES			
B – OTHER DEBT PAYMENTS (ie Credit Cards, Consumer Debt, etc.)			
OTHER VEHICLES and EQUIPMENT			
OTHER: (Credit cards, Installment loans, Personal debts, etc.)			
List:			
B. TOTAL DEBT PAYMENTS			
PART ONE TOTAL (A + B)			

PART 2 - HOUSEHOLD INCOME

APPLICANT (Wages, Tips, Overtime, etc.)**EMPLOYER** ____________			
CO-APPLICANT (Wages, Tips, Overtime, etc.) **EMPLOYER** ____________			
BUSINESS INCOME:			
OTHER (Social Security, Retirement, Alimony, Child support, VA, Welfare, Other income, etc.) **LIST:**			
PART 2 TOTAL			

PART 3 - ASSETS

i. CHECKING ACCOUNT: **Bank:**	**Address:**	**Acct #:**	Balance:
ii. SAVINGS ACCOUNT: **Bank:**	**Address:**	**Acct #:**	Balance:
iii. OTHER ACCOUNTS: **Bank:**	**Address:**	**Acct #:**	Balance:
CDs, STOCKs, BONDs:		**Acct #:**	Value:
TOTAL OTHER ASSETS: (Real estate, Machinery, etc.)			Value:
PART 3 TOTAL (total of i,ii,iii above)			

PART 4 - SUMMARY

A. TOTAL INCOME (PART 2 TOTAL)			
B. CASH (PART 3 TOTAL)			
C. TOTAL EXPENSES AND DEBT PAYMENTS (PART 1 TOTAL)			
D. ***BALANCE (A + B - C)***			
E. 50% of D. Balance (= Minimum Patient Responsibility)			

The information stated in this application is correct to the best of my knowledge. You are authorized to check my credit and employment history and to answer questions about your credit experience with me.

You are further authorized to disclose any information contained herein and other information obtained by you with regard to my credit and employment history to third parties, solely for the purpose of obtaining financing for payment of any indebtedness that I might owe you.

By signing this agreement I am promising to cooperate with the hospital staff and provide adequate information in a timely matter to get my bill resolved.

_________________________________ _________________________
Signature of Applicant Date

_________________________________ _________________________
Signature of Co-Applicant Date