# FINANCIAL EVALUATION FORM

## Schedule of Current Income and Expenditures

Patient:	Spouse:				
Address:					
Phone:					
Social Security number: (patient)		(spouse)			
FAMILY STATUS					
List all dependents you support	· · · · · · · · · · · · · · · · · · ·	· · ·			
Name	Age		Relationship		
	<u> </u>				
EMPLOYMENT AND OCCUPATION					
Employer:	Position:				
Contact person:					
If self-employed, give name of business:					
Spouse's employer:	Positio	on:			
Contact person:	Phone				
If self-employed, give name of business:					

CURRENT MONTHLY INCOME		
	Patient	Spouse
		·
Gross pay from employment (before deductions)	\$	\$
Income from operating business (If self employed)	\$	\$
Other income:		
Interest and dividends	\$	\$
From real estate or personal property	\$	\$
Social Security	\$	\$
Other—specify:	\$	\$
Alimony, support payments	\$	\$
Total current monthly income	\$	\$
(add all figures from above)		
MONTHLY EXPENSES		
Rent or house payment	S	e a
Food	\$	
Utilities (electricity, water, etc.)	\$	<del></del>
Automobile payment	\$	
Other transportation expense (gasoline, bus, etc.)	\$	***
Telephone	\$	THE PROPERTY AND ADDRESS OF THE PROPERTY A
Insurance (home, automobile, life, etc.)	\$	***
Credit cards/other debt	\$	***
Other	\$	

#### UNUSUAL EXPENSES OR INCOME

Please provide information on any unusual expenses or income such as previous medical bills, a recent bankruptcy, court judgments or one-time earnings. You may write on the back of this page or attach a separate listing.

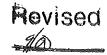
AGGIS AND DEDIG	
Please provide your best estimate of the value of any homes, cars or similar assets. A indicate how much debt you currently have.	
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Assets:			
	a. Home and property	\$	
	b. Automobiles	\$	
	c. Retirement plan	\$	
	d. Investments/other (specify)	\$	
Debts:			
	a. Amount owed on mortgages	\$	
	b. Amount owed on automobiles	\$	
	c. Amount owed on credit cards	\$	
	d. Other (specify)	\$	
My/our signa information of credit history.	ature(s) on this form gives Sample on the form including permission to c	Hospital authorization to veri contact employers and to check	fy the my/our
(Date)	(Signature	of Patient or Guarantor)	
(Date)	(Signature	Spouse)	

## SURPRISE VALLEY HEALTH CARE DISTRICT

## **CHARITY CARE DETERMINATION FORM**

Business Office Manager	
I have reviewed the attached complete	d charity care application fo
following recommendation:	
Signature	
Accounting Department	
Year to date Charity Write-Off \$	(including above).
Additional Comments:	
Signature	Date
Administrator	
I have reviewed the attached completed approve Disapprove	d charity care application ar Reason for Disap
Signature	Date
Board of Directors	
have reviewed the attached completed Approve Disapprove	d charity care application ar Reason for Disappr
Signature	Date



Reviewed

- Introduction
- LIHEAP Leveraging Reports
- All Leveraging/Supplements
- Current Ratepayer-Funded Programs
- Performance Measures

#### **Performance Measures**

- Overview
- Where Grantees Can Learn More
- Contact

#### Contacts

- · Clearinghouse
- State Directors
- Tribal Directors
- Territories

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### Federal Poverty Guidelines for FFY 2014

Size of family unit	100 Percent of Poverty	110 Percent of Poverty	125 Percent of Poverty	150 Percent of Poverty	175 Percent of Poverty	185 Percent of Poverty	200 Percent of Poverty
1	\$11,490	\$12,639	\$14,363	\$17,235	\$20,108	\$21,257	\$22,980
2	\$15,510	\$17,061	\$19,388	\$23,265	\$27,143	\$28,694	\$31,020
3	\$19,530	\$21,483	\$24,413	\$29,295	\$34,178	\$36,131	\$39,060
4	\$23,550	\$25,905	\$29,438	\$35,325	\$41,213	\$43,568	\$47,100
5	\$27,570	\$30,327	\$34,463	\$41,355	\$48,248	\$51,005	\$55,140
6	\$31,590	\$34,749	\$39,488	\$47,385	\$55,283	\$58,442	\$63,180
7	\$35,610	\$39,171	\$44,513	\$53,415	\$62,318	\$65,879	\$71,220
8	\$39,630	\$43,593	\$49,538	\$59,445	\$69,353	\$73,316	\$79,260

For all states (except Alaska and Hawaii) and for the District of Columbia.

Note: For optional use in FFY 2013 and mandatory use in FFY 2014

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