

**MOUNTAIN COMMUNITIES HEALTHCARE DISTRICT – Confidential Financial Statement (Application)**

(Please see below for required documentation)

Patient Name _____	DOS: _____
Patient Number _____	<b>Confidential Financial Statement (Application)</b>

**RESPONSIBLE PARTY**

Name	Marital Status	Social Security Number
Street Address, City, State, Zip	How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)		Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net
		Length of current employment

**SPOUSE**

Name	Social Security Number
Employer Name and Address	Business Phone
Position / Title	Monthly income – Gross
	Monthly income – Net
	Length of current employment

**DEPENDENTS**

Name & Year of Birth of all persons in household	Total Number of Persons in Household _____	Do Any Other Persons Contribute? If Yes, Amount: Yes/No _____ Amount _____
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**INCOME PER MONTH & ASSETS**

Dividends, Interest	\$	<b>Child Support / Alimony</b>	\$
Public Assistance / Food Stamps	\$	Rental Income	\$
<b>Social Security</b>	\$	Grants	\$
Unemployment Compensation	\$	IRA	\$
Workers' Compensation	\$	Other	\$
Savings	\$		\$

**EXPENSES PER MONTH**

Mortgage / Rent	\$	Balance: \$	Medical / Dental	\$
Own Home? (Yes/No)			Doctor – Name	
Food	\$		Doctor – Name	\$
Utilities:			Doctor – Name	\$
Electric	\$		Credit Cards:	\$
Gas	\$		Visa	Limit
Water / Sewer	\$		MasterCard	Limit
Trash	\$		Discover	Limit
Phone	\$		Other	Limit
Cable	\$		Installment Loans	\$
Auto Payments	\$		Child Support	\$
Auto Expenses	\$		Miscellaneous Expenses	\$
Insurance:	\$			\$
Auto Premium	\$			\$
Life Insurance	\$			\$
Health Insurance	\$			\$

OFFICE USE ONLY	To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.  _____ <b>PATIENT/GUARANTOR SIGNATURE</b>
Gross income _____	
Net income _____	
Total Expenses _____	
Total Net income(loss) _____	
	_____ <b>DATE</b>

Please include the following documentation:

- 1) Denial from Medi-Cal/CMSP
- 2) A copy of your last filed taxes or 2 of your most current check stubs
- 3) Your most recent bank statement
- 4) Copies of bills to support your payments