Huntsville Hospital
Huntsville Hospital for Women & Children
Madison Hospital
Decatur Morgan Hospital
Helen Keller Hospital
Red Bay 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 **<u>your</u>** 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? ______

INCOME AND EXPENSES

Do you have an attorney working on your case? ___________ Attorney Name: ________________________________

MONTHLY INCOME	**MONTHLY EXPENSES** **If expenses are shared, please list **your** portion only**
Gross wages/employment **(**patient**)** ______________________	Rent or House/Trailer payment _________________
Net wages after taxes (patient) __________________________	Land/lot payment ____________________________
Gross wages/empl (**spouse**) ___________________________	Utilities __________Gas _________Water________
Net wages after taxes (spouse) __________________________	Food_____________ Phone bill amt ____________
Gross wages/salary **(parents**) ___________________________	Car payment ___________Car Insurance _________
Net wages after taxes (parents) __________________________	Car payment ___________Car Insurance _________

(If patient is a child-please list income for both parents)

Child support/alimony payment _________________

Social Security check amt (**patien**t) ________________________

Daycare/childcare expense _____________________

Social Security check amt (**spouse**) ________________________

Education/college loans________________________

Social Security check amt (**child**) _________________________

List all insurance premiums paid:

SSI Income **(list amt & whom is receiving)** _________________	Hospital/daily indemnity ______________________
Military, Reserves, VA income ____________________________	House/renters insurance_______________________
Short/long term disability income _______________________	Health ins: __________Student ins: _____________
Child support/alimony received __________________________	Life/burial ins: ________ Cancer ins: ___________
Unemployment check amount___________________________ (Monthly payments)	Doctor & medical expenses_____________________
Retirement/pension check amt___________________________	____
Workman's Compensation_______________________________	Prescription costs____________________________ (Out of pocket)
Rental income received _________________________________	
AFDC/Family Assistance_______________________________	Credit Card Name: ____________ pmt___________
Food Stamps received__________________________________	Credit Card Name_____________ pmt___________
Church assistance received______ ________________________	Bank loan Name: _____________ pmt___________
Other income/$ received_________________________________	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** _______________

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Medassist Rep:________________________________ **Financial Counselor:** __________________________________