



Gibson Area Hospital & Health Services - Gibson Cares Program

PATIENT INFORMATION

Patient Name	Date of Birth	Telephone No.	Patient Number
Home Address		Rent <input type="checkbox"/> Own <input type="checkbox"/>	Live with parents? Yes <input type="checkbox"/> No <input type="checkbox"/>
City, State, Zip		Social Security Number	Marital Status
Name and Address of Employer		How Long Employed?	Telephone Number
If Unemployed, Last Date & Place of Employment		Position/Title	Supervisor's Name

SPOUSE INFORMATION

Name	Date of Birth	Social Security Number
Name and Address of Employer	How Long Employed?	Telephone Number
If Unemployed, Last Date & Place of Employment	Position/Title	Supervisor's Name

Total Number in Family _____	Names and Ages of Children
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MONTHLY INCOME

ASSETS

Item	<input type="checkbox"/> Patient <input type="checkbox"/> Spouse	<input type="checkbox"/> Parent <input type="checkbox"/> Spouse	<input type="checkbox"/> Parent <input type="checkbox"/> Spouse	Checking Account(s) (bank & account #)	Balance
Net Monthly Income					
Social Security				Savings Account(s) (bank & account #)	Balance
Interest/Dividends				Other (bank & acct. #) (money market, CD, IRA)	Balance
Rental Income				Life Insurance (company & account #)	Value
Alimony/Child Support				Stocks and Bonds (company)	Value
Unemployment				Furniture	Value
State Assistance				Automobiles/Trucks (make, model, year)	Value
Food Stamps					
Pension					
Disability				Other Assets (personal, livestock, machinery, motorcycle, RV, boat)	Value
Workman's Compensation					
Other				Real Estate (list and describe)	Present Value
Other					
Total				Total Assets:	

PLEASE COMPLETE THE INFORMATION AS THOROUGHLY AS POSSIBLE SO THAT AN ACCURATE ASSESSMENT OF YOUR CURRENT FINANCIAL SITUATION CAN BE DETERMINED. ALONG WITH THE FINANCIAL STATEMENT, THE FOLLOWING ITEMS ARE REQUIRED FOR REVIEW:

1. Most recently filed federal and state income tax
2. Bank account statement (checking and savings)
3. Verification of income (paycheck stubs, unemployment check, Social Security checks, etc.)
4. Proof of application for State & Federal assistance.

MONTHLY EXPENSES		OTHER EXPENSES	MONTHLY PAYMENT	BALANCE	PAYMENT CURRENT?												
ITEM	MONTHLY PAYMENTS	CHARGE ACCOUNTS (LIST)			<input type="checkbox"/> Yes <input type="checkbox"/> No												
Rent					<input type="checkbox"/> Yes <input type="checkbox"/> No												
Mortgage					<input type="checkbox"/> Yes <input type="checkbox"/> No												
Cell Phone					<input type="checkbox"/> Yes <input type="checkbox"/> No												
Gas/Propane					<input type="checkbox"/> Yes <input type="checkbox"/> No												
Electricity					<input type="checkbox"/> Yes <input type="checkbox"/> No												
Water		Personal Loan (Name & Purpose)			<input type="checkbox"/> Yes <input type="checkbox"/> No												
Refuse		Automobile Loan (Name)			<input type="checkbox"/> Yes <input type="checkbox"/> No												
Telephone		Real Estate Loan (Name)			<input type="checkbox"/> Yes <input type="checkbox"/> No												
Cable TV		Miscellaneous (Name & Purpose)			<input type="checkbox"/> Yes <input type="checkbox"/> No												
Food					<input type="checkbox"/> Yes <input type="checkbox"/> No												
Clothing					<input type="checkbox"/> Yes <input type="checkbox"/> No												
Medicine					<input type="checkbox"/> Yes <input type="checkbox"/> No												
Baby Sitter		Total	Total Monthly Payments	Total Balance													
Alimony/Child Support																	
Transportation		SUMMARY															
Auto Insurance		<table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">Total Monthly Income:</td> <td style="width: 10%; text-align: center;">\$</td> <td style="width: 30%; border-bottom: 1px solid black;"></td> </tr> <tr> <td>Total Monthly Expenses:</td> <td style="text-align: center;">\$</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Discretionary Income:</td> <td style="text-align: center;">\$</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Monthly Payment Arrangement:</td> <td style="text-align: center;">\$</td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>				Total Monthly Income:	\$		Total Monthly Expenses:	\$		Discretionary Income:	\$		Monthly Payment Arrangement:	\$	
Total Monthly Income:	\$																
Total Monthly Expenses:	\$																
Discretionary Income:	\$																
Monthly Payment Arrangement:	\$																
Home Insurance																	
Life Insurance																	
Health Insurance																	
Personal Property Tax																	
Real Estate Tax																	
Subtotal																	

OTHER INFORMATION

Will the patient be unable to work or go to school due to physical impairment? Yes No

If so, what is the disabling condition or diagnosis?

Comments: _____

PATIENT AGREEMENT

The undersigned applies for financial assistance in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The creator will retain the original or a copy of this application, even if financial assistance is not granted. The undersigned also agrees to allow GAHHS to contact any or all of the above referenced for credit verification, including credit bureaus. The falsification of data may result in the reversal of any financial assistance.

Patient Signature: _____ Date: _____

Responsible Party or Spouse Signature _____ GAHHS Representative _____