Financial Disclosure Application for Voucher Program

PATIENT INFORMATION:

Last Name: ____________________________ **First Name:** ____________________ **S.S.#:** ________________________ **DOB:** _________________

Mailing Address: ____ **Phone:** _______________**Cell:** __________________

____

Actively Employed? ______ **Retired?** _______ **Disabled?** ______ **Employer:** ___________________________________ **How Long?** ____________

Occupation: ___________________________________

SPOUSE OR SIGNIFICANT OTHER INFORMATION:

Last Name: ____________________ **First Name:** ___________________ **MI:** ___ **S.S.#:** ________________________ **DOB:** _________________

Is Spouse/Partner employed? ______ **Retired?** _______ **Disabled?** ______ **Employer:** ____________________________ **How Long?** ____________

Income for spouse/significant other: ____ **Person:** _______________________

Occupation: ____ **Total Number of Dependents/Household Members:** __________________________

Names of All Dependents/Household Members:

Name: ________________________________ **Age:** ___ **Name:** _________________________________ **Age:** ___

Name: ________________________________ **Age:** ___ **Name:** _________________________________ **Age:** ___

Name: ________________________________ **Age:** ___ **Name:** _________________________________ **Age:** ___

Are any Family/Household Members Covered by Medicaid? ____ **Food Stamps/GA/Fuel Asst?** ______ **How Much? $**__________________________

Have you Applied for Medicaid? ___________ **When?** ________________

REAL ESTATE / PROPERTY INFORMATION:

Do You Rent? _____ **Own?** _____**: House:** _____ **Mobile Home:** _____ **Farm:** _____ **Camp:** _____ **Acreage:** _____ **Value: $** _______________________
Other (Describe): ______________________________ **Mortgage Holder(s):** ____

ESTIMATED HOUSEHOLD INCOME:

Gross Wages	**$ ______________/Month**	**Child Support**	**$ ______________/Month**
Pensions	**$ ______________/Month**	**Unemployment**	**$ ______________/Month**
Social Security	**$ ______________/Month**	**Food Stamps**	**$ ______________/Month**
W/Comp	**$ ______________/Month**	**Interest/Dividends**	**$ ______________/Month**
Rental	**$ ______________/Month**	**Other**	**$ ______________/Month**

I AM REQUESTING FINANCIAL ASSISTANCE WITH TYRONE HOSPITAL. I CERTIFY ALL OF THE INFORMATION PROVIDED BY ME IN THIS FINANCIAL AID PACKET IS TRUE AND ACCURATE. TYRONE HOSPITAL HAS MY PERMISSION TO PURSUE ANY AREA FOR VERIFICATION OF PERTINANT INFORMATION.

Signature of Patient/Guarantor: ____ **Date:** ____

Signature of Spouse: ____ **Date:** ____
(Both patient and spouse/significant other must sign this form)