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**INCOME INFORMATION**

	RESPONSIBLE PARTY	SPOUSE
MONTHLY WAGES (BEFORE DEDUCTIONS)	_____	_____
MONTHLY ALIMONY/CHILD SUPPORT	_____	_____
MONTHLY DISABILITY/ WORKERS COMP	_____	_____
MONTHLY PENSION	_____	_____
MONTHLY SOCIAL SECURITY	_____	_____
MONTHLY DIVIDENDS/ INTEREST	_____	_____
MONTHLY RENTAL INCOME	_____	_____
MONTHLY ESTATE/ TRUST	_____	_____
MONTHLY WELFARE/ PUBLIC ASSISTANCE	_____	_____
MONTHLY FOOD STAMPS	_____	_____
MONTHLY OTHER INCOME (PLEASE LIST)	_____	_____
LESS FICA/ STATE/ FEDERAL TAXES	_____	_____
LESS ANY OTHER DEDUCTION	_____	_____
MONTHLY INCOME TOTAL	_____	_____
COMBINED MONTHLY INCOME (Line 1, Page 4)		_____

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HAVE YOU EVER FILED FOR BANKRUPTCY? YES \_\_\_ NO \_\_\_ YEAR \_\_\_\_\_ DISCHARGE \_\_\_ DISMISS \_\_\_\_\_

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**ASSETS**

	RESPONSIBLE PARTY	SPOUSE
CASH/ CHECKING	_____	_____
INVESTMENTS/ STOCKS/ BONDS	_____	_____
SAVINGS	_____	_____
LIFE INSURANCE	_____	_____
RESIDENCE	_____	_____
OTHER	_____	_____

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**MONTHLY EXPENSE INFORMATION**

	BALANCE DUE	MONTHLY PAYMENT
RESIDENCE PAYMENT (RENT____ OWN____)	_____	_____
OTHER REAL PROPERTY (LIST_____)	_____	_____
ALIMONY/CHILD SUPPORT PAYMENT	_____	_____
VEHICLE 1 PAYMENT (MAKE____ YEAR____)	_____	_____
VEHICLE 2 PAYMENT (MAKE____ YEAR____)	_____	_____
VEHICLE 3 PAYMENT (MAKE____ YEAR____)	_____	_____
RECREATION VEHICLE (LIST_____)	_____	_____
OTHER VEHICLE (LIST_____)	_____	_____
MONTHLY EXPENSE TOTAL (Line 2, Page 4)		_____

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**MEDICAL EXPENSE INFORMATION**

MEDICAL PROVIDER NAME	BALANCE OWED	MONTHLY PAYMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
MEDICAL EXPENSE TOTAL (Line 3, Page 4)		_____

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**OTHER CREDITOR EXPENSE INFORMATION**

NAME OF CREDITOR	TYPE OF LOAN	BALANCE OWED	MONTHLY PAYMENT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
OTHER CREDITOR EXPENSE TOTAL (Line 4, Page 4)			_____

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**OTHER MONTHLY EXPENSE**

AUTOMOBILE (INSURANCE/ GASOLINE/ REPAIRS)	_____
GROCERIES	_____
INTERNET/ TELEPHONE/ TELEVISION	_____
MEDICAL INSURANCE	_____
UTILITIES (ELECTRICITY/ GAS/ SEWER/ WATER)	_____
OTHER MONTHLY EXPENSE TOTAL (Line 5, Page 4)	_____

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**MONTHLY FINANCIAL SUMMARY**

MONTHLY INCOME TOTAL (From Page 2) \_\_\_\_\_

MONTHLY EXPENSE TOTAL (From Page 3) \_\_\_\_\_

MEDICAL EXPENSE TOTAL (From Page 3) \_\_\_\_\_

OTHER CREDITOR EXPENSE TOTAL (From Page 3) \_\_\_\_\_

OTHER MONTHLY EXPENSE TOTAL (From Page 3) \_\_\_\_\_

NET MONTHLY INCOME \_\_\_\_\_

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**PATIENT CONDITIONS AND COMMENTS**

PLEASE PROVIDE ANY ADDITIONAL INFORMATION AFFECTING YOUR ABILITY TO PAY FOR SERVICES PROVIDED AT OUR FACILITY.  
ATTACH A SEPARATE SHEET IF NECESSARY.

HAVE YOU APPLIED FOR MEDICAID? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES AND YOU WERE DENIED OR FOUND TO BE INELIGIBLE, PLEASE EXPLAIN.

\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU ASKED FOR ASSISTANCE FROM YOUR FAMILY? YES \_\_\_\_\_ NO \_\_\_\_\_ EXPLAIN:

\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU ASKED FOR ASSISTANCE FROM YOUR CLERGY/CHURCH? YES \_\_\_\_\_ NO \_\_\_\_\_ EXPLAIN:

\_\_\_\_\_  
\_\_\_\_\_

HOW MUCH ARE YOU ABLE TO PAY EACH MONTH? EXPLAIN:

\_\_\_\_\_  
\_\_\_\_\_

A MINIMUM MONTHLY PAYMENT OF \_\_\_\_\_ IS REQUIRED ON MY COMBINED ACCOUNTS.

WITH THIS APPLICATION I AM REQUESTING A LOWER MONTHLY PAYMENT OF \_\_\_\_\_

I HERBY STATE THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE.

I AUTHORIZE ASHLEY REGIONAL MEDICAL CENTER TO VERIFY THIS INFORMATION, INCLUDING REQUESTING A CREDIT BUREAU REPORT.

I UNDERSTAND THAT IF ANY OF THIS INFORMATION IS DETERMINED TO BE DECEPTIVE OR FALSE,  
I MAY BE DENIED SPECIAL FINANCIAL CONSIDERATION AND  
I WILL BE LIABLE FOR PAYMENT OF ANY AND ALL CHARGES INCURRED FOR SERVICES RENDERED.

RESPONSIBLE PARTY'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_