DAVIESS COMMUNITY HOSPITAL
WASHINGTON, INDIANA
FINANCIAL ASSESSMENT

Patient Name: ______________________ **SSN:** ____________________

Responsible Party: ______________________ **SSN:** ____________________

Address: ____

Account Information:

Discharge Date	Account Number	Patient Name	Acct Balance
________	________	______________	________
________	________	______________	________
________	________	______________	________

Dependents: **Spouse Name**____________________ **Age** ______

 # Of Children under 18 years: ______

Sources of Income:	**Month**	**3 Months**
____________________ HUSBAND EMPLOYER	$__________	$__________
____________________ WIFE EMPLOYER	$__________	$__________
____________________ OTHER INCOME	$__________	$__________
TOTAL	$__________	$__________

Assets

Cash in Bank	$__________	**Property – Home**	$__________
CDs/Investments	$__________	**Property – Other**	$__________
Total	$__________	**Total**	$__________

*****PLEASE COMPLETE, SIGN, DATE AND RETURN WITH PROOF OF INCOME OR NOTARIZED LETTER OF SUPPORT*****

Other Information:

Have you applied for Medicaid? **Yes_______** **No________**

Medicaid Application **Denied _____** **Approved _____** **In-Process______**

Do you have insurance coverage?
If yes, Name of the Insurance: ____

"I certify the information and all statements contained in this Financial Assessment are correct and complete. I authorize the hospital to verify any information contained herein, including the Credit Bureau, Employment Office and Financial institutions. I understand that untrue or incomplete information is cause for denial."

Responsible Party Signature ________________________________ Date ____________________

INSTRUCTIONS

1. **Sign and date the Financial Assessment form.**
2. **Attach proof of income paystub or most current tax form.**
3. **Provide notarized letter of support if unemployed – letter from person or organization currently supporting you.**
4. **Mail the completed form to:**

Daviess Community Hospital
PO Box 32
Washington, Indiana 47501

The Financial Assessment form can be delivered in person to the hospital business office.

For Office Use Only:

Verification by Paycheck Stub __________ **IRS Form W2 _________________** **IRS 1040 ______________**

Employer statement ____________ **Employer Verbal ________________** **Date received: ________________**

Other Comments:

____

____

____

Application: **Approved ____________** **Denied ____________** **% Level ___________________**

Signature of Financial Counselor ________________________________ **Date _________________**

Signature of Authorized Level ________________________________ **Date _________________**