Daviess Community Hospital

Financial Assessment

Patient name: _____ SSN: _____

Responsible party: _____ SSN: _____

Address: _____

Account information:

Discharge date	Account no.	Patient name	Acct. balance
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Dependents:

Spouse name: _____ Age: _____

Number of children under 18: _____

Sources of income:	**Monthly:**	**Yearly:**
Husband's employer*	$_____	$_____
Wife's employer*	$_____	$_____
Other income*	$_____	$_____
Total:	$_____	$_____

**Please complete, sign, date, and return with proof of income or notarized letter of support.*

Assets:

Cash in bank: $_____ Property (home): $_____

CDs/Investments: $_____ Property (other): $_____

Total: $_____

Daviess Community Hospital

Other information:

Have you applied for Medicaid: ☐ Yes ☐ No Medicaid application: ☐ Approved ☐ Denied ☐ Processing

Do you have insurance coverage? ☐ Yes ☐ No

If yes, list the name of insurance: _____

Are you a US citizen? ☐ Yes ☐ No

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 (one month of paystubs or proof of income showing gross income).
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, IN 47501 or hand-deliver it to the hospital's 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: _____