

# Financial Assistance Assessment Form | 2017

Moab Regional Hospital

**General Information:**

Patient Name:	Guarantor Number:
Social Security Number:	Date of Birth:
Address:	Phone Number:
Responsible Party:	Relationship:
Social Security Number:	Date Of Birth:
Address:	Phone Number:
<i>Single    Married/Significant Other    Divorced/Separated    Widow/Widower</i>	
Spouse's Name:	
Social Security Number:	Date of Birth:
Address:	Phone Number:
Name(S) and age(s) of dependents living with you for whom you are responsible	
_____	
_____	
_____	
_____	
List any other additional household members:	
_____	
_____	
_____	
_____	

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## Income:

Last year's total adjusted income (as reported to the IRS):

*If you did not file taxes please explain:*

Current Employer (Or last date of employment if unemployed):      Employer address:

Occupation:      Employer phone:

Length of employment:      Hours worked a month:

Are you collecting unemployment?

Do you have more than one job?      If yes please provide details:

Spouse's current employer (Or last date of employment if unemployed):      Employer address:

Occupation:      Employer phone:

Length of employment:      Hours worked a month:

Is your spouse collecting unemployment?

Does your spouse have more than one job?      If yes please provide details:

Please list any additional employment information:

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## State Assistance:

Do you receive food stamps?

Do you have medical benefits?

If no, have you applied for Medicaid?      Date Applied:

If benefits were denied, what reason was given?

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Monthly Basis	Yours	Spouse	Assets	Value
Gross Pay			Current Home	
Alimony/Child Support			Other Property	
Social Security			Vehicle(s)	
Unemployment/Work Comp			Stock, Bonds, Mutual Funds, 401 K and Annuities	
Interest/Rental			Savings Account 1	
Other			Savings Account 2	
Other			Checking Account	
Other			Other	

Expenses:		
	Monthly Payment:	Total Owed:
<b>Mortgage/Rent</b>		
<b>Home/Renter's Insurance</b>		
<b>Telephone</b>		
<b>Electricity</b>		
<b>Gas</b>		
<b>Water</b>		
<b>Cable</b>		
<b>Auto Loans</b>		
<b>Transportation</b>		
<b>Life Insurance</b>		
<b>Health Insurance</b>		
<b>Medical Bills</b>		
<b>Prescriptions</b>		
<b>Food</b>		
<b>Child Care</b>		
<b>School Expenses/Loans</b>		
<b>Alimony/Child Support</b>		
<b>Credit Card Bills</b>		
<b>Other</b>		
<b>Other</b>		
<b>Monthly Total</b>		

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REQUIREMENT: Copy of your last 6 months of pay stubs for you, your spouse or significant other, 3 months bank statements (that includes personal/savings/business accounts) and it must show your name and account number. Last year's tax returns (all pages) must be submitted with this application. We will deny applications that are incomplete. Your signature is required to complete this application.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge. I understand that Moab Valley Healthcare requires verification of income before any determination is made.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_