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:
Single *Married/Signifigant Other* *Divorced/Separated* *Widow/Widower*	
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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Moab Regional Hospital

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:	

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?	

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

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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:_____