Edgerton Hospital and Health Services
Financial Information Statement

Patient Name:_____Medical Record #_____

Guarantor Name_____Relationship to Patient:_____

Marital Status (check one): ❑Married ❑Single ❑Separated ❑Divorced ❑Widowed

Patient / Guarantor	**Spouse / Other Household Member**
	Name:_____
Social Security Number:_____	Social Security Number:_____
Address:_____	Address:_____
_____	_____
County:_____Home Phone:_____	County:_____Home Phone:_____
If unemployed, last date worked:_____	If unemployed, last date worked:_____
Most Recent Employer:_____	Most Recent Employer: _____
Employment Dates:_____	Employment Dates:_____
Employer Address:_____	Employer Address:_____
_____	_____
Employer Phone:_____	Employer Phone:_____
Job Title:_____	Job Title:_____
❑Full Time ❑Part Time Hourly Wage:_____	❑Full Time ❑Part Time Hourly Wage:_____
Monthly Income	**Monthly Income**
Gross Monthly Income:_____Net_____	Gross Monthly Income:_____Net_____
Social Security Income: $_____	Social Security Income: $_____
Pension $_____	Pension $_____
Rental Property Income: $_____	Rental Property Income: $_____
Unemployment Compensation: $_____	Unemployment Compensation: $_____
Dividends/Interest: $_____	Dividends/Interest: $_____
Child Support or Alimony: $_____	Child Support or Alimony: $_____
Other:_____ $_____	Other:_____ $_____
Other:_____ $_____	Other:_____ $_____
Total Income: $_____	**Total Income: $**_____

Total Combined Monthly Income: $_____

Continued on next page.

Monthly Expenses

Guarantor Monthly Expenses		**Spouse/Other Household Members Monthly Expenses (if applicable)**	
Mortgage Payment:	$_____	Mortgage Payment:	$_____
Rent Payment:	$_____	Rent Payment:	$_____
Real Estate Taxes:	$_____	Real Estate Taxes:	$_____
Utilities (Electricity, Gas, Water):	$_____	Utilities (Electricity, Gas, Water):	$_____
Car / Truck Payment:	$_____	Car / Truck Payment:	$_____
Auto / Home Insurance:	$_____	Auto / Home Insurance:	$_____
Cable TV / Satellite:	$_____	Cable TV:	$_____
Telephone:	$_____	Telephone:	$_____
Cell Phone / Pager:	$_____	Cell Phone / Pager:	$_____
Medication:	$_____	Medication:	$_____
Child Care:	$_____	Child Care:	$_____
Food / Groceries:	$_____	Food / Groceries:	$_____
Auto / Home Maintenance:	$_____	Auto / Home Maintenance:	$_____
Other:_____	$_____	Other:_____	$_____
Other:_____	$_____	Other:_____	$_____
Other:_____	$_____	Other:_____	$_____
Total Expenses:	**$**_____	**Total Expenses:**	**$**_____

Household / Family Bills:

Hospitals and/or Clinics (List Hospital/Clinic names):	Balance:	Monthly Payment
1. _____	$_____	$_____
2. _____	$_____	$_____
3. _____	$_____	$_____

Bank / Credit Union Loans (List purpose of loan):		
1. _____	$_____	$_____
2. _____	$_____	$_____
3. _____	$_____	$_____

Credit Cards or Lines of Credit (List reasons for use):		
1. _____	$_____	$_____
2. _____	$_____	$_____
3. _____	$_____	$_____

If you have additional expenses, please attach a separate sheet.

Total Monthly Expenses: $_____

Continued on next page.

Assets:	Own	Lease	Balance Owed	Name of Financing Institution
Automobiles (year/make/model)				
Snowmobiles/ Off Road Vehicles				
Motorcycle (year/make/model)				
Boats/Recreational Vehicles				
Real Estate				
	Value			
Retirement Account (401K or IRA)				

Other Information:
If you are listing yourself as "UNEMPLOYED," you must provide a description of the reasons for your unemployment, including factors that are preventing you from working:_____
_____

_____

Number of household members (including yourself and all adults & children):_____

Any other remarks for comments that you feel may be useful in determining your eligibility:_____
_____

_____

Authorization:
The information stated in this application is complete and correct to the best of my knowledge. I authorize Edgerton Hospital and Health Services to verify this information, if necessary, and to obtain information from credit reporting agencies. I understand this application and all information herein will remain confidential and will be used only for the purposes of determining my financial responsibility for my charges at Edgerton Hospital and Health Services.

Signature:_____

Spouse/Other Household Member Signature:_____

Date Signed:_____

❑Check here if this form was completed via telephone.
If checked, name of person whom obtained information:_____

IMPORTANT NOTE TO APPLICANTS:
You must include the following items in order for your application to be considered:

- ❑ 3 forms of household income (previous years tax returns, pay stubs, bank statements, etc.).
- ❑ County Medical Assistance (Medicaid) Denial for each patient who has received services through Edgerton Hospital and Health Services.
- ❑ If receiving Social Security Benefits, VA benefits, or any other government aide, copies of these statements showing amount of benefits must be included.
- ❑ If listing yourself as unemployed, you must include a statement of reasons, including what is preventing you from presently working.

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Date Application Received_____Received by_____
Application is complete? ❑Yes ❑No
All household members' income and expenses are disclosed? ❑Yes ❑No
All documentation attached?

- ❑ 3 forms of household income (previous year's tax returns, pay stubs, bank statements, etc.).
- ❑ County Medical Assistance (Medicaid) Denial for each patient who has received services through Edgerton Hospital and Health Services.
- ❑ If receiving Social Security Benefits, VA benefits, or any other government aide, copies of these statements showing amount of benefits must be included.
- ❑ If listing yourself as unemployed, you must include a statement of reasons, including what is preventing you from presently working.

Credit Report? ❑Yes ❑No

ACTIONS TAKEN:	Date / Initials

Percentage to be Written Off		**100%**	**80%**	**60%**	**40%**	**20%**
		Percentage to Poverty Level				
# in Household	**Yrly Income**	125%	150%	175%	200%	225%
1	$ 11,490.00	$14,362.50	$17,235.00	$20,107.50	$22,980.00	$ 25,852.50
2	$ 15,510.00	$19,387.50	$23,265.00	$27,142.50	$31,020.00	$ 34,897.50
3	$ 19,530.00	$24,412.50	$29,295.00	$34,177.50	$39,060.00	$ 43,942.50
4	$ 23,550.00	$29,437.50	$35,325.00	$41,212.50	$47,100.00	$ 52,987.50
5	$ 27,570.00	$34,462.50	$41,355.00	$48,247.50	$55,140.00	$ 62,032.50
6	$ 31,590.00	$39,487.50	$47,385.00	$55,282.50	$63,180.00	$ 71,077.50
7	$ 36,610.00	$44,512.50	$53,415.00	$62,317.50	$71,220.00	$ 80,122.50
8	$ 39,630.00	$49,537.50	$59,445.00	$69,352.50	$79,260.00	$ 89,167.50
9	$ 43,650.00	$54,562.50	$65,475.00	$76,387.50	$87,300.00	$ 98,212.50
10	$ 47,670.00	$59,587.50	$71,505.00	$83,422.50	$95,340.00	$107,257.50

❑ APPROVED:
Percentage of Community Care write-off:_____

❑ DENIED:
Reason:_____

Acct Number	Date of Service	Dollar Amt.	Write Off GL

Total Amount Approved for Community Care

Date of Final Determination:_____ Authorized by:_____

Date Applicant Notified:_____Notified by:_____

Notes: