APPALACHIAN REGIONAL HEALTHCARE, INC.
FINANCIAL EVALUATION

Unit Name: **Code:**

PATIENT NAME:_____ DATE:_____

MAIL ADDRESS:_____ CITY:_____ STATE:_____

ZIP CODE:_____ SOCIAL SECURITY #_____ Phone#:_____

GUARANTOR:_____ RELATIONSHIP:_____

GUARANTOR SOCIAL SECURITY #:_____ Phone #:_____

THIRD PARTY INSURANCE:_____

GROUP:_____ CERTIFICATE:_____ DEDUCTIBLE:_____

CO-PAY:_____ PRIVATE-PAY AMOUNT:_____

COPY OF INCOME TAX RETURN – ATTACH VERIFICATION OF HOUSEHOLD INCOME – ATTACH

SAVINGS ACCOUNT AMOUNT_____ CHECKING ACCOUNT AMOUNT_____

CREDIT UNION ACOUNT_____ CERTIFICATES OF DEPOSIT AMT._____

STOCK AMOUNT_____ BOND AMOUNT_____

PROPERTY OWNED – VALUE_____ OWNED RENTAL PROPERTY VALUE_____

RENTAL PROPERTY INCOME_____ VALUE OF VEHICLES_____

VALUE OF BOATS, ETC._____ HOME VALUE_____

INVESTMENT INCOME_____ RETIREMENT INCOME_____

DISABILITY INCOME_____ ALIMONY_____

TAX DEFERRED ANNUNITIES_____ 401K VALUE_____

INCOME TAX REFUND_____ OTHER INCOME_____

IRA VALUE_____ TOTAL INCOME:_____

TOTAL VALUE OF ASSETS_____

IS PATIENT ELIGIBLE FOR CHARITY: YES_____ NO_____ MEDICAID DSH:YES_____ NO_____

IF MEDICAID DSH ELIGIBLE COMPLETE DSH FORM AND ATTACH F/E & COPIES OF ALL VERIFICATION OF INCOME, BANK STATEMENTS, TAX RECORDS, ETC.

Guarantor Dependents (must be on income tax return)_____

ESTIMATED AMOUNT DUE:$_____ PAYMENT AMOUNT:$_____ MONTHS:_____

GUARANTOR SIGNATURE:_____ DATE:_____

EVALUATOR:_____ APPROVED:_____

DATE:_____ DATE:_____