APPALACHIAN REGIONAL HEALTHCARE, INC.
FINANCIAL EVALUATION

Unit Name: **Code:**

PATIENT NAME:_____ **DATE:**_____

MAIL ADDRESS:_____ **CITY:**_____**STATE:**___

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

GUARANTOR:_____**RELATINSHIP:**_____

GUARANTOR SOCIAL SECURITY #:_____**PHONE#** ***HOME:***_____ ***WORK:***_____

FAMILY SIZE:_____ **INSURANCE COVERAGE: NO**_____ **YES**_____

Family Members/Relations/Age	/	Family Members/Relations/Age
	/	
	/	
	/	

INCOME: IS ANY ONE CURRENTLY EMPLOYED?_____**SALARY PER HR?**_____**HOURS WORKED/WEEK?**_____

EMPLOYMENT	/	**WELFARE/Fd STAMPS**
UMWA/PENSION	/	**OTHER-EXPLAIN**
SOCIAL SECURITY	/	**SELF-EMPLOYED"**
WHO RECEIVES?		
TOTAL MONTLY GROSS INCOME		

SAVINGS ACCT AMT._____ **CHECKING ACCT AMT.**_____

CREDIT UNION ACCT._____ **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**_____

TAX DEFERRED ANNUNITIES_____ **401K VALUE**_____

INCOME TAX REFUND_____ **IRA VALUE**_____

TOTAL VALUE OF ASSETS_____

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

EXPENSES:

HOUSE/RENT PAYMENT	/	**ELECTRIC/WATER**
PHONE/TV/GARBAGE	/	**FOOD**
ALIMONY/CHILD SUPP	/	**AUTO/INS/OTHER**
MEDICAL PAYMENTS		

IS PATIENT ELIGIBLE FOR CHARITY: YES_____**NO**_____ **MEDICAID YES**_____**NO**_____

Guarantor Dependents (must be on income tax return)_____

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

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.

GUARANTOR SIGNATURE:_____**DATE:**_____

EVALUATOR:_____**APPROVED:**_____

DATE:_____**DATE:**_____