Patient Name: _____
FC: _____ MRN: _____
Sex: ____ DOB: _____ Age: _____
Adm Date: _____ ACCT: _____

Financial Evaluation

APPALACHIAN REGIONAL HEALTHCARE, INC.
FINANCIAL EVALUATION

Unit Name: **Code:**

PATIENT NAME: _____ **DATE:** _____
MAIL ADDRESS: _____ **CITY:** _____ **STATE:** _____
ZIP CODE: _____ **SOCIAL SECURITY #** _____ **Phone#:** _____ **DOB:** _____

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

INSURANCE COVERAGE: NO ❑ **YES** ❑

THIRD PARTY INSURANCE _____
GROUP: _____ **CERTIFICATE:** _____ **DEDUCTIBLE:** _____
CO-PAY: _____ **PRIVATE-PAY AMOUNT #** _____

FAMILY SIZE: _____

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 MONTHLY 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 ANNUITIES _____ **401K VALUE** _____
INCOME TAX REFUND _____ **IRA VALUE** _____
TOTAL VALUE OF ASSETS _____

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

Pt Name: _____ Sex: _____ DOB: _____ Age: _____ FC: _____ MRN: _____ Date of Service: _____

Financial Evaluation

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 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:** _____

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

GUARANTOR SIGNATURE: _____ **DATE:** _____

EVALUATOR: _____ **APPROVED:** _____

DATE: _____ **DATE:** _____

FINAVAL