PATIENT FINANCIAL STATUS STATEMENT

IN ORDER TO EXPEDITE YOUR APPLICATION, PLEASE FOLLOW THE INSTRUCTIONS BELOW CAREFULLY

Please be prepared to provide:

A copy of your most recent bank statement
A copy of your federal income tax forms from the previous year – If you are a student and are claimed on your parent(s) taxes, please enclose a copy of their most recent tax forms
A copy of your proof of income
If applicable, a copy of the court decree for alimony/child support
If applicable, Small Business owners must send proof of current income & quarterly income taxes including Schedule C

Your application will not be processed without the above listed items
Enter applicant information. If a student, indicate the information on the top right side of the application.

Section 1: Please enter the name, address and telephone numbers of the applicant and, if applicable, the name and address of the spouse/significant. Please circle whether you are married, single, widowed or divorced.

Section 2: Provide the name of the employer for both the applicant and a spouse/significant, along with the employer's address and the effective date of employment.

Section 3: Provide ALL monthly income for both the applicant and spouse/significant.

Section 4: Provide the total monthly income, the total number of family members in the household, as well as names and birth dates of the household members.

Section 5: This section MUST be completed in order for your application to be processed. Provide all of your asset information including: Checking, Savings, 401K, IRA, Christmas and Vacation clubs and any other information as it pertains to your assets. A copy of your most recent back statement must be provided. If a section is not applicable indicate by writing N/A.

Section 6: Provide your monthly expenses, writing N/A in those fields that do not apply to you. Remember to enter your monthly grocery bill and other utilities, as well as insurance and car payments. If you are currently living with someone who is paying all of your monthly expenses, please have them complete the enclosed form.

Sign and date the application and return it to: United Hospital Center, PO Box 2308, Clarksburg, WV 26301

Additional space has been provided for you to explain sources of other income or monthly earnings, other assets or liabilities.

The following may not be covered under the charity program: i.e. services related to accidents where there may be third party liability; any elective services not covered by your health insurance coverage.

All claims are reviewed prior to the charity deduction being applied. If it is determined at the time that your situation has changed or fraudulent information was supplied, you may be responsible for the bill. If it is determined that your situation has changed, your account will be reviewed to determine if you are eligible for Medical Assistance.

AT ANY TIME, IF YOU HAVE A QUESTION, REMEMBER TO CALL US AT 624-2960.

UNITED HOSPITAL CENTER – CLARKSBURG, WV
PATIENT FINANCIAL STATUS STATEMENT

[%]_____/_____-____/____/____

Patient Name: _____

Patient Name: _____

NCO [ ] From:_____

Ful Time Student:_____Yes or _____No

College attending: _____

Living with Parents: ____Yes or _____ No

Section 1 APPLICANT INFORMATION

Name:_____

Date of Birth: ___/___/___

Social Security Number:___/___/___

Mailing Address:_____

_____

Residence:_____

_____

Telephone:_____

CIRCLE ONE: M S W D

Section 1 SPOUSE/SIGNIFICANT

Name:_____

Date of Birth: ___/___/___

Social Security Number:___/___/___

Mailing Address:_____

_____

Residence:_____

_____

Telephone:_____

CIRCLE ONE: M S W D

Section 2 SOURCE OF INCOME

Employer:_____

Employer Address:_____

_____

Effective Date of Employment: ___/___/___

Section 2 SOURCE OF INCOME

Employer:_____

Employer Address:_____

_____

Effective Date of Employment: ___/___/___

Section 3 MONTHLY EARNINGS

PROOF OF INCOME MUST BE ATTACHED

Earnings from Employer:$_____

OTHER SOURCES-SEND PROOF

Alimony/Child Support:$_____

Black Lung:$_____ Low Earnings:$_____

Retirement:$_____ SSI:$_____

Unemployment:$_____

Workers Comp:$_____

Other:$_____(Please Explain)

Section 3 MONTHLY EARNINGS

PROOF OF INCOME MUST BE ATTACHED

Earnings from Employer:$_____

OTHER SOURCES-SEND PROOF

Alimony/Child Support:$_____

Black Lung:$_____ Low Earnings:$_____

Retirement:$_____ SSI:$_____

Unemployment:$_____

Workers Comp:$_____

Other:$_____ (Please Explain)