


FINANCIAL STATEMENT

	Column 1: Applicant	Column 2: Spouse (If information is identical to column 1, please write "Same" in Column 2.)
Name		
Marital Status		
Date of Birth		
Social Security Number		
Veteran or eligible for VA benefits?		
Dependants	Name	Age
		Circle # for child (if applicable)
(if more than four children, please add information on back)	1	Primary Placement? 1 2 3 4
	2	Do you claim on taxes? 1 2 3 4
	3	Covered by insurance? 1 2 3 4
	4	
Home Address/County		
City, State, Zip Code		
How long at this address?		
Home Phone Number		
Cell Phone Number		
Previous Address (If less than three months)		
How long?		
Employment Information:		
Employer Name		
City, State, Zip Code		
How long employed?		
Gross Income	\$ _____ per _____ _____ Hour _____ Week _____ Mo. _____ Yr	\$ _____ per _____ _____ Hour _____ Week _____ Mo. _____ Yr
Second Employer Name		
City, State, Zip Code		
How long employed?		
Gross Income	\$ _____ per _____ _____ Hour _____ Week _____ Mo. _____ Yr	\$ _____ per _____ _____ Hour _____ Week _____ Mo. _____ Yr
Other Income:	\$	\$
Bonuses	\$ _____	\$ _____
Alimony, Child Support and Maintenance	\$ _____ per mo.	\$ _____ per mo.
Pensions	\$ _____ per mo.	\$ _____ per mo.
Public Assistance	\$ _____ per mo.	\$ _____ per mo.
Social Security	\$ _____ per mo.	\$ _____ per mo.
Social Security Disability Bulk payment received within last three months	\$ _____	\$ _____
Unemployment	\$ _____ per wk.	\$ _____ per wk.

Worker's Compensation	\$	per mo.	\$	per mo.
Interest	\$	per mo.	\$	per mo.
Rental Income	\$	per mo.	\$	per mo.
Other	\$		\$	
Other Assets:	Institution	Amount	Institution	Amount
Savings Account(s)	1		1	
	2		2	
Checking Account(s)	1		1	
	2		2	
Pension Fund Value	\$		\$	
401K Value	\$		\$	
Mutual Funds Value	\$		\$	
Stocks/Bonds/Dividend Value	\$		\$	
IRA/Certificate of Deposit Value	\$		\$	
Vehicles	Make	Model	Year	Value
	1			
	2			
	3			
Other (ATV's, motorcycles, boats, snowmobiles, etc.)	\$		\$	
Life Insurance Cash Value	\$		\$	
Value of Property (other than primary address)	\$		\$	
Other	\$		\$	
Liabilities	\$		\$	
Mortgage/Rent per month	\$		\$	
Mortgages (on property other than primary address)	\$		\$	
Amt of Child Support You Pay (if applicable)	\$		\$	
Heating bill	\$		\$	
Electricity	\$		\$	
Cell/Land Line Phone Bill	\$		\$	
Grocery	\$		\$	
Fuel for vehicles	\$		\$	
Cable/Internet	\$		\$	
Other	\$		\$	
Other	\$		\$	
Other	\$		\$	
Other Loans	Type	Mo Pmt	Amt Owed	Type
	1			1
	2			2
	3			3

Credit Cards	Type	Mo Pmt	Amt Owed	Type	Mo Pmt	Amt Owed
	1			1		
	2			2		
	3			3		
	4			4		

Does your employer offer Private Health Insurance to you?__

If so, what is the dollar figure for the co-premium per month? \$_____

I hereby request that Monroe Clinic personnel make a written determination of my eligibility for uncompensated services at Monroe Clinic. I understand that the information which I submit concerning my annual income and family size is subject to verification by Monroe Clinic. Proof of income will accompany this application or be provided within ten days after application date.

I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

Signature of Applicant/Responsible Party _____

Date of Application: _____

Signature of person accepting application: _____

Eligibility Determination (For Office Use Only)

Account Numbers _____

Income

Assets

Determination: _____% _____
or

Denied and Reason: _____

Signature: _____

Date: _____