JennieStuart MEDICAL CENTER

FINANCIAL DISCLOSURE

GENERAL INFORMATION

Patient Information

Patient account number (Required): Date of Visit:

Name: SSN:
Address: County:
Home phone: Birthdate:
Employer: Work Phone:
Occupation:

Guarantor (or spouse if married):

Name: SSN:
Address:
Employer: Work phone:
Occupation:
Relationship to patient:

Family Information

Family size:

Family member	SSN	Age	Relation to patient
1			
2			
3			
4			
5			
6			
7			
8			

SCHEDULE OF FAMILY RESOURCES

Monthly Family Income

Patient's salary	$	
Spouse's/guarantor's salary	$	
Retirement/pension	$	
Social Security	$	
Net rental/lease cash flow	$	
Interest	$	
Dividends	$	
AFDC/TANF/Welfare	$	
Alimony received	$	
Child support received	$	
Unemployment income	$	
Guard/Reserve/Military pay	$	
Work Comp benefits	$	
Other income/assistance (list):	$	
	$	
Other income/assistance (list):	$	
JSMC Representative:	$ Date:	
	$	
Total monthly income	$	**A**
Annual income = (**A x 12**)	$	**B**
Annual income adjustments (describe):	$	
	$	
	$	
Total income adjustments	$	**C**

Adjusted annual income = (B+C)

1. Adjusted annual income (from page 1) _____ [A]

2. Cash and investments:

a. Bank accounts

Bank name	Account #	Checking/savings	Current balance	
				[A]
				[A]
				[A]

b. Stocks, mutual funds, CD's and other non-retirement investments:

Name/Description	Account #	Type of investment	Current balance	
				[A]
				[A]
				[A]

c. Life insurance/burial plan

Name/description	Policy amount		Cash value

Total cash and investments

3. Home (principle place of residence):

Name/description	Market value of home	Mortg./loan balance	Equity value

4. Other property (individual items greater than $5,000) - attach separate schedule if necessary:

a. Vehicles (include cars, boats, motorcycles, farm equipment, etc.)

Make/model/year	Market value	Mortg./loan balance	Equity value

b. Living (include homes [non-residence], rental property, etc)

Description	Market value	Mortg./loan balance	Equity value

c. Real Estate (include land and other real estate holdings)

Description	Market value	Mortg./loan balance	Equity value

Total other property _____

Total resources (sum of 1-5) _____

Total family resources for charity determination *Sum of [A]* _____

I hereby certify that all information on my application for charity care is correct and complete to the best of my knowledge, information and belief. I understand and agree that if Jennie Stuart Medical Center learns that I have made false statements or misrepresented any information on this application for charity care, it may seek legal action against me to recover the amount of charity care provided, as well as related costs and attorneys' fees. I hereby authorize Jennie Stuart Medical Center to obtain a consumer report, including a credit report, on me in order to consider my application for charity care. I understand that in the event that information in the report is used, in whole or in part, in making an adverse decision regarding my application for charity care, Jennie Stuart Medical Center will provide me with a copy of the report. In the event that an adverse decision is based on information contained in my consumer report, I understand I will be given a written description of my rights under the Federal Fair Credit Reporting Act.

Applicant signature: _____ Date: _____

Person supplying information
(if different from applicant): _____ Relationship to applicant: _____

JSMC Representative: _____ Date: _____

Please mail completed form and attachments to:
Jennie Stuart Medical Center
Financial Counselors
320 W 18th Street
PO Box 2400
Hopkinsville, KY 42240