Charleston Area Medical Center

501 Morris St.
PO Box 1547
Charleston, WV 25326

* F I 2 0 2 5 *

PATIENT FINANCIAL APPLICATION

ACCOUNT #

Name: _____ **DOB:** _____

Patient Address: _____**Phone#:**_____

Employer: _____ **Employment Status**:_____

Name of Guarantor and/or Spouse: _____**Relationship:**_____ **DOB**: _____

No. of dependents in Family: Please include names and birthdates _____
(under 18 or under 21 full time student)

Presumptive Eligibility: The Patient/Guarantor is currently enrolled in a state-sponsored entitlement or financial assistance program.

Program Name: _____

Name of Document(s) Verifying Program Eligibility: _____

INCOME: Please list income for family (even if qualifying under presumptive eligibility shown above). Provide copy of the most recent Federal Tax Return and/or the most recent Pay Stubs. If not qualifying under Presumptive Eligibility above.

Check here ____if not required to file a federal tax return.

WAGES for Family monthly:

EMPLOYMENT:	$_____	SELF EMPLOYMENT:	$ _____
UNEMPLOYMENT COMP:	$_____	SOCIAL SECURITY/Pensions(s):	$_____
WELFARE/PUBLIC ASSIST:	$_____	CHILD SUPPORT/ALIMONY:	$_____
DISABILITY INCOME:	$ _____	MISC. (INTEREST, RENT):	$ _____
ALL OTHER INCOME:	$_____		

ASSETS FOR Family:

OWN HOME:____ CURRENT BALANCE: $_____ VALUE: $_____
OTHER PROPERTY OWNED: ____ CURRENT BALANCE: $_____ VALUE: $_____

Auto 1: ___ MAKE/MODEL: _____YEAR:_____ CURRENT BALANCE: $_____ VALUE: $_____
Auto 2: ___ MAKE/MODEL: _____YEAR: _____ CURRENT BALANCE: $_____ VALUE: $_____

RECREATIONAL: _____ MAKE/MODEL:_____YEAR: _____BALANCE: $_____ VALUE: $_____
ADDITIONAL ASSETS_____ BALANCE: $_____ VALUE: $_____

Bank:

SAVINGS ACCOUNT: CURRENT BALANCE: $_____
CHECKING ACCOUNT: CURRENT BALANCE: $_____
STOCKS/BONDS: CURRENT BALANCE: $_____
Assets exceed charity criteria? __Y__N

EXPENSES MONTHLY:

MORTGAGE/ RENT:	$_____	HEATING:	$_____
ELECTRIC:	$_____	WATER/SEWAGE:	$ _____
CABLE/SATELLITE:	$_____	PHONE/CELL/LANDLINE:	$_____
CREDIT CARD(S):	$_____	MEDICAL BILL(S):	$_____
INSURANCE/ LIFE:	$_____	PHARMACY:	$ _____
FOOD:	$_____	MISC: (list)	$ _____
CAR PAYMENTS:	$_____	PROPERTY TAXES:	$_____

I solemnly swear/or affirm that the forgoing statements in this application are true and correct to the best of my knowledge and belief. I further authorize the employer, institutions and/or Credit report to release information to CAMC.

Signature of Applicant: _____ DATE: _____

FOR HOSPITAL USE ONLY

INCOME VERIFIED BY:

_____ EMPLOYER VERIFICAITON

_____ PAYROLL STUBS/SOCIAL SECURITY

_____ INCOME TAX RETURN

_____ CHECKING AND/OR SAVINGS ACCOUNT

_____ PROGRAM ELIGIBILTY DOCUMENTATION PROVIDED FOR PRESUMPTIVE

BUDGET ANALYSIS

INCOME:

GROSS: $_____

OTHER INCOME: $_____

TOTAL INCOME: $_____

LESS EXPENSES:

FROM EXPENSE PAGE: $_____

BALANCED OWNED/REQUESTED: $_____

AMOUNT OF CHARITY REQUESTED: $_____

DISPOSITION:

APPROVED: _____ YES _____ NO

REASON: _____

SIGNATURE: _____ DATE: _____

DISPOSITION (IF ANY) TO HFS:

SETTLEMENT AMOUNT: $_____

APPROVED MONTHLY PAYMENT(s): $ _____

APPLICATION TAKEN BY:_____ DATE:_____