(Attachment A)

GRANITE FALLS MUNICIPAL HOSPITAL AND MANOR

APPLICATION FOR CHARITY CARE and FINANCIAL DISCLOSURE STATEMENT

Date Completed:______________________

Name of Individual Completing Form:___________________________

This section to be filled out by hospital:
Patient Name:_________________________
Hospital Billing #:______________________
Medical Record #:______________________

Filing this application does not guarantee approval. The determination for eligibility for charity care is a judgement made by hospital personnel, executives, or board members based on guidelines that are outlined in the Granite Falls Municipal Hospital Charity Care Policy.

Name:_____________________________________
Spouse:____________________________________
Address:___________________________________
____
Phone:_____________________________________

Dependents (list each by name/age below)
___________________________________ Age____
___________________________________ Age____
___________________________________ Age____
___________________________________ Age____
___________________________________ Age____
___________________________________ Age____

Cash Assets:

Checking Account: $______________
Savings: $______________
CDs: $______________
Stocks: $______________
Bonds: $______________

Total Cash Assets $______________

Non-Cash Assets:

Market Value – Mortgage Balance = Equity

Homestead ________ - _________ = _________
Other property ________ - _________ = _________
Auto-Truck (1) ________ - _________ = _________
Auto-Truck (2) ________ - _________ = _________

Total Other Asset Equity $_____________

Income:

Complete the information below based on household income (add all incomes of working members of household).

Source of Income	Monthly Amount	Annual Amount
Wages or Salary	$	$
Net Income from Self-Employment	$	$
Net Income from Farm	$	$
Social Security	$	$
Dividends-Interests-Rentals-Royalties	$	$
General Assistance	$	$
Pensions and Annuities	$	$
Unemployment Compensation	$	$
Worker’s Compensation	$	$
Alimony	$	$
Child Support	$	$
Other (Please Specify)	$	$
	$	$
TOTAL INCOME	$	$

Uses of Cash:

Uses of Cash	Balance Owing	Monthly Payment
Bank Loans	$	$
Credit Cards	$	$
House Payment/Rent	$	$
Car/Truck Payment(s)	$	$
Insurance Payment(s) Car & Home	$	$
Utilities	$	$
Fuel (Car)	$	$
Medical Bills(s)	$	$
Food/Clothing Allowance	$	$
Other (Please Specify)	$	$
	$	$
TOTAL BILLS (MONTHLY)	$	$

I authorize Granite Falls Municipal Hospital to verify any information given on this application with my employer. I understand that if asked, I will submit a copy of my previous year's Federal Income Tax return or other documentation such as paycheck stubs, Social Security Income check stubs, unemployment verification, or personal property tax receipts.

____ ___________________

Patient or Responsible Party Date

List Required Documents Here