

# FINANCIAL STATEMENT



Payment arrangements may be considered based on your ability to pay. To verify information on this statement the following documentation is required:

- ✓ Photocopy of your latest income tax return and all schedules.
- ✓ Photocopy of your two current paycheck vouchers and/or pay stub from your previous employer
- ✓ Photocopy of your statement of unemployment benefits
- ✓ Photocopy of your statement of monthly entitlement for Federal, State, or County Assistance Programs.
- ✓ If you are on Social Security, a copy of your latest benefit statement or SSA-1099
- ✓ Photocopy of your two current checking/savings statements
- ✓ Photocopy of your VA pension plans.

Name \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Home Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, St., Zip \_\_\_\_\_  
 Name of Children and DOB : \_\_\_\_\_  
 \_\_\_\_\_

Significant Other \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Home Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_  
 No. of Children claimed on income tax return \_\_\_\_\_  
 No. of people in household \_\_\_\_\_  
 \_\_\_\_\_

### EMPLOYMENT

Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Length of Employment \_\_\_\_\_  
 Start Date: \_\_\_\_\_  
 Previous Employer: \_\_\_\_\_

Significant Other's Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Length of Employment \_\_\_\_\_  
 Start Date: \_\_\_\_\_  
 Previous Employer: \_\_\_\_\_

### ASSETS

Asset	YR	Description	Value	Creditor	Balance Owing	Pay Amt	# Payments Delinquent
Home							
Car							
Car							
Boat/Rv							
Rec. Vehicle							
Land							
Cert/Dep							
Life Insurance							
Other							
Other							
Investments:							

### OTHER RESOURCES

Have you applied for Medicaid ?  Yes  No      Have you applied for Social Security Disability?  Yes  No  
 If Yes:      Application Date: \_\_\_\_\_      Check one:  Approved  Denied  
 If denied, list reason for denial: \_\_\_\_\_

Does anyone (parent, grandparent, friends, etc.) assist with your expenses?  Yes  No  
 If Yes:      Relationship: \_\_\_\_\_      Amount of Assistance Received Monthly: \$ \_\_\_\_\_

Have you filed bankruptcy in the last 7 years?  Yes  No  
 If Yes:      Check one:  Chapter 7  Chapter 13      Date Filed: \_\_\_\_\_      Date Discharge: \_\_\_\_\_

**OTHER DEBTS**

	Reason for Debt	Creditor	Present Balance	Payment	# of Pymts. Delinquent
Credit Card					
Credit Card					
Credit Card					
Credit Card					
Bank Loan					
Bank Loan					
Medical Debt.					
Medical Debt.					
Medical Debt.					
Medical Debt.					
Other					

**BANKING**

Cash on Hand: \_\_\_\_\_

Checking Acct: Bank \_\_\_\_\_ Account # \_\_\_\_\_  
 Address \_\_\_\_\_ Acct. Balance \_\_\_\_\_

Savings Acct: Bank \_\_\_\_\_ Account # \_\_\_\_\_  
 Address \_\_\_\_\_ Acct. Balance \_\_\_\_\_

**MONTHLY EXPENSES**

Rent or House Payment _____	Rental / Home: _____	Life _____
Food (include eating out) _____	Insurance _____	Other _____
Clothing _____	Other _____	Automobile: _____
Household: _____	Education _____	Monthly Payment _____
Heat _____	Recreation _____	Monthly Payment _____
Electricity _____	Subscriptions _____	Gas/Oil _____
Telephone _____	Gifts _____	Insurance _____
Cell Phone _____	Child Care _____	License _____
Satellite/Cable TV _____	Child Support (Paid-out) _____	Maintenance/Repair _____
Internet Access _____	Alimony (Paid-out) _____	<b>Total Expenses:</b> \$ _____
Water &/or Sewer _____	Insurance: _____	
Repairs _____	Medical _____	

**MONTHLY INCOME**

Applicant's Gross Wages _____ <small>(Tips, Overtime, etc.)</small>	_____ \$ _____	Rental of Land or Buildings _____
Paid: Monthly _____ Weekly _____ Biweekly _____	RR Retirement _____	Gross Monthly Income: _____
Significant Other's Gross Wages _____ <small>(Tips, Overtime, etc.)</small>	Workers Comp. _____	<b>Total Monthly Income:</b> _____
Paid: Monthly _____ Weekly _____ Biweekly _____	Unemployment _____	
Net Business/Farm Income _____	Retirement Benefits _____	
Other income: _____	Social Security _____	
Type                      Amount	Alimony _____	
_____ \$ _____	Delinquent: ___ Yes ___ No	
_____ \$ _____	Child Support _____	
	Delinquent: ___ Yes ___ No	

*I certify the above information is true and correct. I understand that the purpose of this information is to assist Trinity Health in determining my eligibility for assistance and in finding an acceptable payment plan. I authorize Trinity Health to contact the employers and institutions on this application to verify it's accuracy. I further authorize the employers/institutions to release such information to Trinity Health.*

Signature \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_