Patient/Responsible Party Questionnaire

1. Patient Name **Social Security #** **D. O. B.** **Hospital Name** **Account #**

2. Patient/Responsible Party Name **Relationship to Patient** **D.O.B** **Social Security #**

3. Address **City, State Zip** **Length of Residence**

4. Previous Address (if less than 2 yrs at above) **City, State Zip** **Length of Residence** **Phone Number**

5. Marital Status **# of Dependents in household (Names and Ages)**

6. Employer (Patient/Responsible Party)	**7. Previous Employer (Patient/Responsible Party)**	**8. Spouse Employer**
Address		
Job Title/Length of employment		
Business Phone		
Hourly Rate		
Monthly Income Gross		
Monthly Income Net		

9. Other Income Source/Amount **Total Family Monthly Income** **Total Family Income last 12 mos.**

10. Have you applied for Medicaid or any other State/County Assistance? (check one) **Yes_____** **No_____**
Patient/Responsible Party Questionnaire Date **Caseworker Name/Phone number**
11. Have you filed Bankruptcy?_____ Chapter 7_____ Chapter 13_____ Date Filed_____ Discharge Date _____
12. Are you a Homeowner? Yes / No Approx. $ Value Approx. Balance on Loan Years left on Loan

13. Bank Name **Checking Acct.#** **Avg. Checking Acct. Balance** **Savings Acct.#** **Avg. Savings Acct. Balance**

14. Automobile (s)
Make_____Model_____Year_____Pmt. Amt._____Balance Due_____
Make_____Model_____Year_____Pmt. Amt._____Balance Due_____
15. Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)

	Monthly Payment	**Payment to**	**Acct #**	**Balance Due**	**Limit**
Rent/Mortgage	**$_____**	_____			
Credit Cards	**$_____**	_____			
	$_____	_____			
	$_____	_____			
Bank Loans	**$_____**	_____			
	$_____	_____			
School Loans	**$_____**	_____			

List Other Monthly Expenses:

	Monthly Payment		**Monthly Payment**		**Monthly Payment**
FOOD	**$_____**	**MEDICATION**	**$_____**	**AUTO INS**	**_____**
UTILITIES	**$_____**	**LIFE INSURANCE**	**$_____**	**OTHER**	**_____**
GAS (Automobile(s))	**$_____**	**MEDICAL BILLS**	**$_____**	**OTHER**	**_____**
	$_____	**TOTAL MONTHLY PAYMENTS**			

***Note: Attach additional sheet if necessary. Important: income verification must be attached: W-2, Pay Stub, Tax Return, etc.**

1. **I, the undersigned, certify that the above information is true and accurate to the best of my knowledge.**
2. **I will apply for any and all assistance that may be available to help pay this hospital bill.**
3. **I understand the information submitted is subject to verification: therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of Hartgrove Hospital information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I further authorize Hartgrove Hospital to perform a credit check as to both patient/responsible party and spouse.**

Signature_____Date_____Witness_____Date_____