849 South Three Notch Street
P. O. Box 760
Andalusia, Alabama 36420
Phone: (334) 222-6910

PERSONAL INFORMATION FACT SHEET

INSTRUCTIONS: The patient or the party responsible for the patient's financial arrangement with the Hospital should complete this form. This form is not an application for credit and will not be used to determine whether credit can be extended to you. Under the Hospital's policies, all accounts are due at the time services are rendered or when the patient receives the Hospital's billing summary. The information on this form will be used for the purpose of helping the Hospital determine whether you may be eligible for assistance for Hospital Services and to provide background information about your ability to discharge your financial obligations to the Hospital.

To qualify the information below needs to be completed in full and proof of all income (including copy of most current W2 forms, pay check stubs and bank statements 3 mo.) into the household needs to be attached and mailed. Also include any monthly bills, ie…Electric, house ect… **Without proof you cannot qualify.** There is a good faith payment required prior to review of your application. This payment will be applied toward your account. Please see Financial Counselor for amount of payment required.

Patient Name: ____ SS # _____ - ____ - _____

Address: ____ Phone ________________

____

List every member of the household:

Name:	Social Security #	Date of Birth
___________________________	_____- _____- _____	_______________
___________________________	_____- _____- _____	_______________
___________________________	_____- _____- _____	_______________
___________________________	_____- _____- _____	_______________
___________________________	_____- _____- _____	_______________

Income		Expenses	
Description	Monthly Income	Description	Monthly Expenses
A. Gross Salary Husband Name: ______________		A. Rent/ House Pymt	$ ________
		B. Food	$ ________
		C. Utilities (elect, water, phone, gas)	$ ________
Net Salary Employer Name: ______________	$ ________	D. Repairs (Car/Home)	$ ________
B. Gross Salary Wife Name: ______________		E. Installment Loans List: ______________ ______________	$ ________
Net Salary: Employer Name: ______________	$ ________	F. Car Payment	$ ________
		G. Charge Account	
		- Visa	$ ________
C. Dividend/Interest	$ ________	- Master Card	$ ________
D. Pension Income	$ ________	- Discover	$ ________
E. Self Employment	$ ________	- Other List	$ ________
F. Social Security	$ ________	H. Taxes	$ ________
G. Alimony/Child Support	$ ________	I. Insurance	$ ________
		J. Medical Expenses	$ ________
		K.	$ ________

For Hospital Use Only:

List Account Numbers: ______________ ______________

______________ ______________

Approved by: ______________________ Date: __________

Supervisor: ______________________ Date: __________