PRINCETON COMMUNITY HOSPITAL

FINANCIAL ASSISTANCE APPLICATION FOR ELIGIBILITY DETERMINATION

______________________ Patient's Name	______________________ Date of Request
______________________ Address	______________________ Telephone No.
______________________ Request Made By Whom	

Number of Persons in Family______________________

Total Family Income Last Twelve (12) Mos. $______________________

If you are seeking Financial Assistance for services by Princeton Community Hospital, List Date of services: ______________________

____

I understand that the information on which I submit is subject to verification by Princeton Community Hospital and subject to review by federal and / or state enforcement agencies and others as required. I certify that the above information is true and correct. If any information I have given proves to be untrue, I understand that the Hospital may reevaluate my financial status and take whatever action becomes appropriate.

____
(s) Person Making Request

- -

This document was received on______________________ by ______________________

CONDITIONAL DETERMINATION: Date ______________ Medicaid Denial Date______________

Patient is required to ______________________

____

____

before final approval or denial can be made.

APPROVAL: Date ______________ By: ______________________

DENIAL: Date ______________ By: ______________________

Reason:______________________

____

ORIGINAL - JOURNAL 2ND COPY - PATIENT FILE 3RD COPY - CONDITIONAL DETERMINATION

FINANCIAL ASSISTANCE AND MONTHLY PAYMENT DETERMINATIONS
PRINCETON COMMUNITY HOSPITAL

Responsible Party _____ **Age** _____

Married _____ **Divorced** _____ **Separated** _____ **Widow** _____ **Single** _____

Spouse _____ **Age** _____ **No. Dep.** _____

Residence _____ **Length** _____

Mailing Address _____ **Phone** _____

Previous Address _____ **Length** _____

Employer _____ **Length** _____

Previous Employer _____ _____ **Length** _____

Income _____ **Monthly/Weekly** **Other Income** _____

Spouse's Employer _____ **Length** _____

Income _____ **Monthly/Weekly**

Bank Accounts _____ **Balance of Checking** _____ **Balance of Savings** _____ **CD** _____
(Name of Bank)

Nearest Relative _____ **Relation** _____

Address _____ **Phone** _____

Spouse's Relative _____ **Relation** _____

Address _____ **Phone** _____

Rent, Own or Buying? _____ **In Whose Name?** _____

Mortgage Held By: _____ **Monthly Payment** _____ **Balance Due** _____

Automobile? _____ **Make** _____ **Year** _____ **Model** _____

_____ **Make** _____ **Year** _____ **Model** _____

Automobile Payment Made To: _____ **Balance Due** _____ **Payment** _____

_____ **Balance Due** _____ **Payment** _____

I hereby agree to pay to Princeton Community Hospital a sum of at least $_____ per month, and more when possible, commencing _____ and each month thereafter until paid in full.
Contracts will be reviewed periodically to try to increase payments, if possible.
I hereby authorize Princeton Community Hospital, or any agency employed by them to investigate any references or data listed herein pertaining to my credit or financial responsibility.
I understand that should there be an overpayment on any of my present and future accounts, such overpayment would be transferred to this account.
I understand that accounts are to be settled in full each month, unless other arrangements are made.

Date_____ Signature_____
Date _____ Spouse's Signature_____

Date: _____ Reviewed By: _____
Date: _____ Reviewed By: _____
Date: _____ Reviewed By: _____
Date: _____ Reviewed By: _____

ADDITIONAL FINANCIAL INFORMATION
PRINCETON COMMUNITY HOSPITAL

BILLS	COMPANY NAME	MONTHLY PAYMENT	BALANCE DUE
Water			
Sewer			
Electric			
Trash			
Phone			
Cable			
Internet			
Cell Phone			
Home/Trailer Insurance			
Oil/Gas for Home			
Car Insurance			
Groceries			
Gas for Car			
Day Care			
Medicine			
Trailer Rent			
Lot Rent			
Student Loans			
Credit Card			
Credit Card			
Credit Card			
Doctor			
Doctor			
Doctor			
Hospital			
Hospital			
Hospital			
Miscellaneous			
Miscellaneous			
Miscellaneous			
Total of Bills			

Date: _____ Responsible Party Signature: _____
Date: _____ Responsible Party Signature: _____
Date: _____ Responsible Party Signature: _____
Date: _____ Responsible Party Signature: _____