BINGHAM MEMORIAL HOSPITAL
SKILLED NURSING & REHABILITATION CENTER • IDAHO DOCTORS' HOSPITAL

Financial Statement Application Form

Patient:			Account #:
Account #	Account #:		Account #:
All Questions Must Be Answered *Put N/A if not Applicable* *Use Second Sheet of Paper for Additional Information*			
Patient *(If patient is a minor, use father's information)*			
Name:			Social Security #:
Address:			Birthdate:
City, State, Zip Code:			How Long Resided?
Telephone #			Marital Status:
Previous Address:			
Employer & Address:			
Previous Employer & Address			
Dependents			
Name	**Date of Birth**	**Social Security #**	**Living In your Household**
Nearest Relative Not Living With You:			Phone # :
Address:			Relationship:
Spouse *(If patients is a minor – mother's information)*			
Name:			Social Security #:
Address:			Date of Birth:
City, State, Zip Code:			How Long Resided?
Telephone #			Marital Status:
Previous Address:			
Employer & Address:			
Previous Employer & Address			
FINANCIAL INFORMATION: *(Include ALL Household Income)*			
Household Gross Income $	Monthly Take Home Income $		Other Income $
Social Security $	Retirement/Pension $		IRA $
Certificate Of Deposit $	Stocks/Bonds/ Annuities $	Welfare $	Food Stamps $
Home: Own ☐ Renting ☐ Buying ☐ Other ☐			Monthly Payment $
Paid To:	Property Value $		Balance Owing $
Vehicles:			
Year/Make/Model	**Monthly Auto Payment**	**Balance Owed**	**Paid To**
Recreational Vehicles :			
Year/Make/Model	**Monthly Payment**	**Balance Owed**	**Paid To**

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Financial Information *(continued)*

MONTHLY EXPENSES
*(Include payments **ONLY** if not deducted by your employer on your payroll check)*

	Current	Past Due		Current	Past Due
Rent or House Payment	$	$	Child Care	$	$
Power	$	$	Phone	$	$
Gas/Oil Heat	$	$	Gasoline	$	$
Water, Sewer, Trash	$	$	Groceries	$	$
Child Support	$	$	Health Insurance	$	$
Auto Insurance	$	$	Life Insurance	$	$
Medications	$	$	Fines/Garnishments	$	$
Auto Payments	$	$	Other_____	$	$

Medical Bills, Credit Cards, Loans, & Other Debts *(include any taxes, dues, etc.)*

		Balance Owing	Monthly Payment
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$

Release of Information:

I hereby authorize and direct any hospital or physician who has attended me, any and all Idaho County entities, the State of Idaho Department of Health and Welfare, all federal government agencies (i.e., Social Security Administration, Veterans Administration) and all creditors, banks and lending institutions to release any and all information they may have pertaining to me and any member of my family to Bingham Memorial Hospital for their examination and/or copying thereof, upon their request. In addition, I authorize Bingham Memorial Hospital to obtain my credit report to verify all financial information.

This information includes but is not limited to applications, decisions, records, medical and otherwise, reports, bills and invoices.

I further authorize Bingham Memorial Hospital to release to you whatever information they may have or receive pertinent to any application I have or will make for assistance from any local, state or federal entity.

A photocopy of this authorization may be used in lieu of the original.

_____
Signed

_____
Date

Financial Information *(continued)*

1. Proof of all gross (pretax) income for the responsible party, including paycheck stubs or last year's federal tax return, child support, alimony, or social security income statement; and/or your unemployment compensation letter.
2. Proof of residency, including a copy of one of the following: a gas, electric, phone or cable bill (within 6 days of the hospital service) a rent receipt, a credit card bill, your voter registration or your driver's license or state identification.

By my signature below, I certify that I have carefully read this application and that everything I have stated or provided in any attachment is true and correct to the best of my knowledge and belief. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

_____ Date completed: _____/_____/_____
Signature of Responsible Party

If you reported $0.00 income on the first page, please have the Support Statement below completed by the person(s) helping you and/or your family.

Support Statement

(To be completed by the person providing support.)

I have been identified by the applicant as providing financial support. Below is a list of services I provide the applicant

_____

_____

_____

_____

_____

I hereby certify and verify that all of the above information is true and correct to the best of my knowledge and belief. I understand that my signature will not make me financially responsible for the patient's medical charges.

_____ _____/_____/_____
Signature Date

_____ _____
Mailing Address City, State, Zip code

Patient Insurance Information

Did the patient have health insurance or Medicaid at the time of the hospital service? **Yes** **No** *(Please Circle One)*

If "**YES**", please attach a copy of the insurance (front and back) or Medicaid card that covers the patient and complete the following:

Name of Insurance Company:_____ Policy Number:_____

Policy Number: _____ Group Number: _____

Insurance Phone Number_____ Medicaid Number _____

Hospital Use Only

By my signature below, I affirm to the best of my knowledge and belief that the information on this application is accurate.

_____ _____
Hospital Representative Signature Date Completed