CLAY COUNTY HOSPITAL
911 Stacy Burk Drive, PO Box 280
Flora, Illinois 62839

FINANCIAL EVALUATION

Date Sent:	Acct #:	Acct#:
Please Return By:	Acct #:	Acct#:
Date Returned:	Acct #:	Acct#:

Patient Name	Age	Phone Number	Marital Status S M W D	Patient Social Security

Patient	Person Responsible for Bill	Relationship
Street	Name	
	Street	
City, State, Zip	City, State, Zip	
Phone: ( )	Phone: ( )	

EMPLOYMENT

Patient's Employer	Person Responsible Employer
Occupation	Occupation
If Unemployed, Name of Last Employer	If Unemployed, Name of Last Employer
How Long Unemployed	How Long Unemployed

LIST BELOW ALL MEMBERS OF HOUSEHOLD (Exclude Patient)

Name	Age	Relationship to Patient

Do you have health insurance coverage available? Yes_____ No_____

If yes, why not available for this date of service? _____

If no, please indicate the reason for lack of insurance coverage: Insurance cost too high yes____ no____, pre-existing condition yes____ no____, other, please describe _____

Have you applied for Medicaid? Yes_____ No _____ Date applied _____

If denied, date: _____ Reason for denial: _____

Please attach a copy of the Medicaid denial letter, if denied.

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MONTHLY INCOME: Attach Copy of Proof of Income			
	Patient	**Spouse**	**Other**
Wages (Gross)			
Social Security			
Pensions			
Unemployment/Work Comp			
Alimony/Child Support			
Government Assistance			
Disability Payments			
Strike Benefits			
Scholarships/Grants			
Dividends/Interest			
Other, List			

EXPENSES	**MONTHLY**	**BALANCE DUE**	**ASSETS - VALUE**	**PATIENT (Joint)**
Mortgage or Rent Payment			Savings	
Car Payment			Checking	
Utilities (Gas, Electric, Water)			Money Market	
Cable			CD's	
Phone			Investments, Stocks, Bonds	
Cell Phone			Home(Market Value)	
Food			Cars/Motorcycles	
Child Care			Make/Model	
Clothing			Year	
Insurance (Auto, Life, Health)			Car #2	
Gas/Transportation			Make/Model	
Recreation			Year	
Pharmaceuticals/Medications			Car #3	
			Make/Model	
Physicians			Year	
			Boats/Other	
Hospitals			Other Property/Real Estate	
			IRA, 401K	
Other Medical				
Credit Cards			**LIABILITIES**	
			Home Loan	
Other Expenses (Describe)			Auto Loan	

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

I VERIFY THE INFORMATION PROVIDED IS CORRECT AND COMPLETE. I AUTHORIZE VERIFICATION OF ANY INFORMATION AND UNDERSTAND THAT ADDITIONAL DOCUMENTATION MAY BE REQUESTED. IF ANY INFORMATION IS FOUND TO BE FALSE, THE FINANCIAL ARRANGEMENT OR ASSISTANCE MAY BE VOIDED.

Patient/Responsible Party Signature Date: