PHONE:	ALTERNATE PHONE:	BEST TIME:
MARITAL STATUS: S/M/D/W	NUMBER IN HOUSEHOLD:	
HOUSEHOLD MEMBERS NAME:	RELATIONSHIP:	DATE OF BIRTH
1	SELF	
2		ADDRESS:
3		
4		
5		

EMPLOYMENT/SELF EMPLOYMENT	HOURS	GROSS MONTHLY AMOUNT RECEIVED
PATIENT		
SPOUSE		

INSURANCE AVAILABLE FROM SELF, SPOUSE OR OTHER		
PATIENT YES/NO		
SPOUSE YES/NO		

UNEMPLOYMENT	GROSS WEEKLY AMOUNT RECEIVED	DEDUCTIONS
PATIENT YES/NO		
SPOUSE YES/NO		

SOCIALSECURITY/RETIREMENT/SSI/MONEY FROM ANOTHER PERSON OR AGENCY/RENTAL PROPERTY	TYPE	GROSS MONTHLY AMOUNT RECEIVED
PATIENT: YES/NO		
SPOUSE: YES/NO		
CHILDREN: YES/NO		

CHILD SUPPORT	GROSS MONTHLY AMOUNT PAID	GROSS MONTHLY AMOUNT RECEIVED
PATIENT: YES/NO		
SPOUSE: YES/NO		
FOR CHILD NOT IN HOME: YES/NO		

MEDICAID	*MEDICAID INFO GIVEN: YES/NO*	
SELF: YES/NO		
CHILDREN: YES/NO		
OTHER MEMBER OF HOUSEHOLD: YES/NO		

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was; listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through Putnam County Hospital. If I am entitled to any action against or settlement from third party payers. I will take any action necessary or requested by Putnam County Hospital to obtain such assistance and will assign to Putnam County Hospital, and upon receipt will pay to Putnam County Hospital, all amounts recovered up to the total amounts of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Putnam County Hospital will result in the denial of this application. I also authorize Putnam County Hospital to check my credit history through the credit bureau if deemed appropriate.

_____ _____

Signature of the Patient (Responsible Party) Date

Expenses	Frequency	Amount
Rent/Mortgage		
Utilities		
Phone		
Child Care		
Child Support Paid		
Medical Expenses (elderly or disabled)		
School Expenses (tuition, books, misc)		
Total		
Assistance Received	**Frequency**	**Amount**
Family or Friends		
Food Stamps		
TANF (AFDC)		
Housing		
Utility		
Prescription		
Township Trustee		
Church		
Food Pantries		
Salvation Army		
School Income (loans, grants, scholarship, etc)		
Veteran's Benefits (GI Bill, etc)		
Other Misc Expenses		
Total		
PCH Personnel to complete		
Item's Received:		
Current State Tax Form		
Current Federal Tax Form		
Current Bank Statement		
Current and Previous Month's Pay Stubs		
Proof of other Income		
Comments		