SOUTHWEST REGIONAL
Medical Center
Committed to Greene

Patient Full Name_____

SS#_____ **Date of Birth**_____ **Age**_____

Address_____

Home Phone #_____ **Cell #**_____

US Citizen: Yes_____ No_____ **Veteran:** Yes_____No_____

Father's Name_____ Mother's Name_____
(Required if patient is a minor)

Employer_____ **Length of Employment**_____

Address_____ **Phone#**_____

Emergency Contact: _____Relationship_____Phone#_____

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced

Spouse Name _____ SS#_____

Employer_____ Phone#_____

Length of Employment_____

Housing: □ Own $_____ (monthly payment) □ Rent $_____ (monthly payment) □ Other$_____

Do You File An IRS-Tax Return: _____Yes _____No

Number of Persons in Household (They must be claimed as a dependent on your IRS tax return):

Total Number Claimed: _____ **List Names and Ages:** _____

_____ _____ _____ _____

Monthly Income:	Patient (or Father of a Minor)	Spouse (or Mother of a Minor)
Earned Income	_____	_____
Social Security	_____	_____
Veterans Administration	_____	_____
Retirement Income	_____	_____
Child Support / Alimony	_____	_____
Unemployment Income	_____	_____
Disability Income	_____	_____

Monthly Allowable Expenses: (If total is over $100.00 please provide receipts; must show proof of child support)

Medication: _____

Health Insurance Premiums: _____

Medical Supplies Requiring Prescription: _____
(Description of Supplies)_____

Child Support Payments: _____

Resources:

Real Estate: (other than primary residence, i.e. rental property,land,etc) ___Yes___No

Taxable Value Less Mortgage: $_____

Cash: $_____

Checking Account: ___Yes ___No Balance: $_____

Savings, CD's, Stocks, Bonds: ___Yes ___No Balance: $_____

IRA, 401K, TSA: ___Yes ___No Balance: $_____

Other Resources $_____

Auto / Recreational Vehicles:

Year/Make/Model	Less Amount Owed
_____	$_____
_____	$_____

I understand that the information within this application will be used to determine payment options and or financial aid regarding my indebtness to Southwest Regional Medical Center. I acknowledge the hospital's need to validate my financial status and give my authorization for a credit investigation into my personal credit history. The information obtained as part of this application will be held in strict confidence and used solely for the purpose of determining my ability to pay for services rendered by SRMC. I also attest that the information is true and accurate to the best of my knowledge and understand any misrepresentation will result in denial of hospital financial aid.

_____ _____
Patient or Representative **Date**

_____ _____
Spouse **Date**

(Office Use Only)
Total Household Monthly Income: _____

Less Total Monthly Medical Expenses: _____

Total Net Monthly Income: _____

Total Adjusted Yearly Income: _____

Total Net Resources: _____