



REGIONS HOSPITAL
Financial Application
640 Jackson Street
St. Paul, MN 55101

Responsible Party/Guarantor Name: _____

Patient's Name: _____ Account Numbers: _____

Date of application: _____

Please answer each question as complete detail as possible. Also, in order to process, a copy of your Federal tax return must be attached. If you or your spouse are currently unemployed, please list the last employer and the hourly wage you were making.

1. Name: _____

2. Social Security #: _____-_____-_____

3. Address: _____

4. Telephone (home): _____ (work) _____

5. Date of birth _____-_____-_____ 6. Current Marital Status: _____

7. Your spouse's name: _____

8. Spouse's address: _____

9. Spouse's social security number: _____-_____-_____ 10. Date of birth: _____

11. Names and ages of dependents living with you:

12. Your place of employment or occupation: _____

Address of employment: _____

13. Title: _____ Hire date: _____ Hourly wage: \$ _____

Take Home Pay weekly \$ _____, Bi-weekly \$ _____, Monthly \$ _____

Your employment status:

Full time _____ Part-time _____ Laid off _____ Other _____

Deductions from paycheck other than taxes: \$ _____

14. Spouse's place of employment or occupation: _____

Spouse's address of employment: _____

Spouse's title: _____ Approx. hire date: _____ Hourly wage: \$ _____

Take Home Pay weekly \$ _____ Bi-weekly \$ _____ or Monthly \$ _____

Spouse's employment status:

Full time _____ Part-time _____ Laid off _____ Other _____

Deductions from paycheck other than taxes: \$ _____

15. Are you buying or renting your home? _____

16. If buying, are you buying on a contract for deed or mortgage? _____

17. Name of contract or mortgage holder _____

18. How long have you lived at this address: _____

19 Do you own other real estate? Yes _____ No _____

If yes, where? _____

Value: \$ _____

20. I/we own the following motor vehicles:

Name of owners	Make	Model	Year	Amount owed	Monthly payment
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21. List recreational vehicles boats, campers, snowmobiles, etc.: _____

22. List other sources of income: Rents: \$ _____ per month
Interest and dividends: \$ _____ per month
Social Security: \$ _____ per month

AFDC or other state or federal support: \$ _____

Pension or other retirement income: \$ _____

Alimony, maintenance or child support payments: \$ _____

Other: _____

23. Where do you bank? _____

Checking: \$ _____ Savings: \$ _____

Cash on hand: \$ _____ CD's \$ _____

Stocks/bonds: \$ _____ Credit Union balance: \$ _____

24. Monthly expenses:

A. Rent or home loan payment: \$ _____ per month.

B. Real estate taxes \$ _____

Are taxes included in your home loan payment? _____ (Y/N).

C. Utilities per month for: Gas \$ _____

Electricity \$ _____

Water/Sewer \$ _____

Telephone \$ _____

D. Prescriptions and/or medical supplies per month

E. Life insurance company name: _____

Cash value \$ _____

Type of life insurance term or whole life _____

Premium amount: \$ _____

Monthly or annually _____

F. Auto insurance company name: _____

Premium amount: \$ _____

Paid Month _____

Quarterly _____

Semi-annually _____

Annually _____

G. Health insurance company name: _____

Premium amount: \$ _____

Paid Monthly _____

Quarterly _____

Semi-annually _____

Annually _____

H. Home owner's or renter's insurance company name: _____

Premium amount: \$ _____

Paid Monthly _____

Quarterly _____

Semi-annually _____

Annually _____

Paid as part of mortgage payment: _____ (yes or no)

25. Monthly installment payments: (list all installment loans, credit cards, medical bills, etc.)

Creditor	Balance Due	Monthly Payments
A. _____		
B. _____		
C. _____		
D. _____		
E. _____		
F. _____		
G. _____		
H. _____		

26. Transportation (not including auto payments): \$ _____

27. Education (including tuition and school books): \$ _____

28. Food per month: \$ _____ Number in household: _____

29. Other expenses (specify): _____

30. Do you plan or have you filed a lawsuit or insurance claim against someone because of an accident or injury? Yes _____ No _____

If yes, attorney's name and phone number:

31. List any pending lawsuits against you: _____

32. List any judgments against you: _____

I understand that the information, which I have provided is subject to verification by Regions Hospital and review by federal and state agencies and for other program, related purposes. I also understand that my application is subject to the guidelines of Regions Hospital and that eligibility will be determined at its sole discretion by Regions Hospital. I certify that the above information is true and correct.

I/We hereby authorize you to provide to Regions Hospital federal and state records of employment and income history, including State Employment Security Agency records through DataStat, Inc. this authorization is for this transaction only and continues in effect for one (1) year unless limited by state law, in which case the authorization continues in effect for the maximum period, not to exceed one (1) year, allowed by law. A photographic or carbon copy of the authorization (of the signatures(s) of the undersigned) may be accepted as the original and may be used as a duplicate original

Date: _____ Signature: _____

Date: _____ Spouse's Signature: _____

You may have a separate billing from the HealthPartners Medical Group for doctors' services. Would you like a copy of this application forwarded to that office, for consideration of any bill with them?

Yes _____ No _____