LIFECARE MEDICAL CENTER - CHARITY CARE

q/vp/charity care 7/16

Patient Name: _____ Date of Birth: _____

#1) Responsible Party: _____ Email: _____ Home/Cell Phone: _____

Address: _____ City/State/Zip: _____

Employer: _____ FT / PT Monthly **Gross** Income: $_____ Other Income: $_____

#2) Responsible Party: _____ Email: _____ Home/Cell Phone: _____

Employer: _____ FT / PT Monthly **Gross** Income: $_____ Other Income: $_____

Family Size _____ Ages of Dependent Children _____

ASSETS

Cash on hand (including checking) $_____
Savings $_____
Stocks/bonds/retirement funds/401K $_____
Vehicles: Estimated Value
Model_____ Year_____ $_____
Model_____ Year_____ $_____
Home: Estimated Market Value $_____
2nd Home/Land: Est. Mkt. Value $_____
Other Assets _____ $_____
Other Assets _____ $_____
(boats, campers, ATVs, snowmobiles)

LIABILITIES

Bank Loans $_____
Total Credit Cards $_____
Home Mortgage - balance $_____
__ Rent __ Own
Other Liabilities _____ $_____
Other Liabilities _____ $_____
Other Liabilities _____ $_____

FIXED MONTHLY EXPENSES

House Payment/Rent $_____
Utilities $_____
Telephone $_____
Cable TV $_____
Medical Bills $_____
Prescription Drugs $_____
Insurance $_____
Groceries $_____
Child Care $_____
Child Support $_____
Other _____ $_____
TOTAL MONTHLY EXPENSES $_____

PROOF OF INCOME: A COPY OF THE FOLLOWING MUST ACCOMPANY YOUR APPLICATION IN ORDER TO PROCESS

Federal Tax Return (First two pages of 1040)
Current Pay Stub (Responsible Party & Spouse)

Self Employed Applicants: Please provide last two complete Federal Tax Returns with profit & loss reportings

Other Income Source Documentation:

__ Social Security __ VA Assistance __ Railroad Retirement __ Child Support
__ Disability __ Life Insurance __ Pension __ Alimony
__ Unemployment __ Workman's Comp __ Public Assistance __ Other - Please list: _____

I hereby acknowledge that the information given to LifeCare Medical Center is true and correct to the best of my knowledge. I authorize LifeCare Medical Center to verify any or all information given.

Patient/Guarantor's Signature _____ **Date** _____

If you have questions regarding this form, please contact our Financial Counselor at 218-463-2500, Monday thru Friday from 8:00 AM to 4:30 PM.