LIFECARE MEDICAL CENTER - CHARITY CARE

q/vp/charity care 5/24

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: $**______________

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 __________	$__________

Family Size _______

Ages of Dependent Children ___________

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