Complete/Return by _____/_____/_____ Staff Initials:_____ Account_____

Nanticoke Memorial Health Services
801 Middleford Road, Seaford, DE 19973 (302) 629-7946
FINANCIAL APPLICATION

Patient Name_____Email Address_____

Address_____

Phone #_____Social Security#_____ Marital Status_____

Employer_____Address_____

US Citizen: Yes_____No_____ Permanent Resident: Yes_____No_____

Spouse/Guarantor Name _____Social Security#_____

Spouse Employer_____Address_____

US Citizen: Yes_____No_____ Permanent Resident: Yes_____No _____

Checking account: Yes _____No_____ Savings Account: Yes_____ No_____

Home Status: Own home _____ Buying_____ Renting_____ Lives w/family_____

Does anyone in your household receive food stamps? Yes _____no_____ ($_____)
Names_____

Does anyone in your household receive Medicaid? Yes _____no_____ ($_____)
Names_____

Does anyone in your household qualify for CHAP (Community Health Access Program) yes ___no___?
Name(s) _____

#of Adults that you report on your tax return _____

#of Children that you report on your tax return _____

Child's name _____Date of Birth _____ Insurance Co. Name_____
Child's name _____Date of Birth _____ Insurance Co Name_____
Child's name _____Date of Birth _____ Insurance Co. Name_____
Child's name_____ Date of Birth _____ Insurance Co. Name_____

PLEASE COMPLETE THE BACK OF THIS APPLICATION

MONTHLY INCOME INFO
(BE SURE TO INCLUDE PROOF OF INCOME)

Patient is paid: Weekly_____ Twice a Month_____

Patient's Gross Monthly Income_____

Patient's Net Monthly Income _____

Spouse is paid: Weekly _____Twice a Month_____

Spouse's Gross Monthly Income_____

Spouse's Net Monthly Income _____

Pension_____

Rental property Income_____

Disability Income _____ _____

Unemployment _____

Child Support/Alimony _____

Social Security Net Income _____

Social Security Gross Income_____

State /Social Services Income _____

Other _____

Comments _____

_____

_____

_____

Total Yearly Gross Income_____

Total Monthly Net Income_____

MONTHLY EXPENSE INFO

Rent/Mortgage
(Pay to whom) _____$_____

Food _____ **Electric _____**

Phone _____ **Heating Oil/Gas_____**

Gas for Auto_____

Car Insurance _____ **Cable_____**

Day Care _____ **Trash_____**

Water/ Sewer _____ **Tuition_____**

Prescriptions_____

Health/Life Insurance_____

Home Owners Insurance _____

Child Support/Alimony _____

To Whom Monthly Amt. Total_____

Car Loan _____

Credit Card_____$_____$_____

Credit Card_____ $_____$_____

Credit Card_____$_____$_____

Credit Card_____$_____$_____

Credit Card_____$_____$_____

Other _____

Total Monthly Expenses_____

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Credit Investigation Authorization

I hereby authorize Nanticoke Memorial Hospital Inc. or its agents to investigate any references, statement, other date given by me or any person pertaining to my credit and financial responsibility. I understand that information given will be used only for the purpose of determining eligibility for a payment plan or possible reduction of charges on my hospital bill only **(will not include charges for physicians, radiologist, pathologist or any other affiliated medical related professionals.)** I affirm that the information given on my assistance is true and correct

Date:_____/_____/_____Witness_____Signature_____