FINANCIAL QUESTIONNAIRE

Hancock Regional Hospital

Return to Patient Financial Services
801 N State Street
Greenfield, IN 46140
(317) 468-4900

MR Number & Account Number to be completed by hospital personnel	*COUNTY*	*Hospital*	*Account Number:*

Please provide the following information completely and accurately. Information is subject to verification.
Please attach a list of additional household members if there are more than five (5) members.

Patient's name (first, MI, Last)	Date of Birth::	Total # Household Members
Address:	Phone numbers: Home: ( ) Work: ( )	
City, ST ZIP:	Responsible if not patient:	

List ALL household member names	**Date of Birth**	**Relation to Patient**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Monthly Income		**Monthly Expenses**	
Responsible Party's Gross Income (before taxes)	**$**	Rent or own	
Other Household Gross Income (before taxes)	**$**	Medical and Pharmacy Bills	**$**
Investment Income (Annuities/Stocks/Dividends)	**$**	Make and model of Car	
Child Support/Alimony Received	**$**	1st –year/make/model	
Rental Property Income	**$**	2nd –year/make/model	
Pension/Retirement/Unemployment	**$**	Pharmacy Expenses	**$**
Other:	**$**	Health Insurance Costs	**$**
Food Stamps (Yes/No)	**$**	Other	**$**
Total Monthly Income (before taxes)	**$**	**Total Monthly Expenses**	**$**

Assets	
Checking Account Balance	**$**
Savings Account Balance	**$**
Other:	**$**

Comments:

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through Hancock Regional Hospital. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by Hancock Regional to obtain such assistance and will assign to Hancock Regional, and upon receipt will pay to Hancock Regional, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Hancock Regional will result in the denial of this application. I also authorize Hancock Regional to check my credit history through the credit bureau, if deemed appropriate.

I also authorize Release of Information from the Division of Family Resources to Hancock Regional Hospital Social Services/Patient Financial Services regarding application approval/denial for Food Stamps and/or Hoosier Healthwise/Medicaid.

Signature of Patient/Responsible Party

Date