Lakeland HealthCare
Medical Excellence. Compassionate Care.

# Confidential Financial Statement

I understand that the information, which I submit concerning my annual income, family size and assets, is subject to verification by Lakeland Healthcare. I also understand that if the information which I submit is determined to be false, such a determination may result in a rejection of this application, and that the balance owing is due and payable immediately.

Customer Number _____ Return no later than _____

| Responsible Party | Spouse/Partner |
|---|---|
| Name _____ | Name _____ |
| Date of birth _____ | Date of birth _____ |
| Social Security Number _____ - ____ - _____ | Social Security Number _____ - ____ - _____ |
| U.S. Citizen Yes No | U.S. Citizen Yes No |
| Permanent Resident Yes No | Permanent Resident Yes No |
| Address _____ | Address _____ |
| _____ | _____ |
| Phone Number (_____) _____ - _____ | Phone Number (_____) _____ - _____ |
| Most recent employer _____ | Most recent employer _____ |
| Date hired _____ Last date worked _____ | Date hired _____ Last date worked _____ |
| ❑ Salary $_____/year $ _____/month | ❑ Salary $_____/year $ _____/month |
| ❑ Hourly Wage $_____ Average hours/week _____ | ❑ Hourly Wage $_____ Average hours/week _____ |
| Other Income source (list monthly amounts) | Other Income source (list montly amounts) |
| ❑ Social Security $_____ ❑ Pension $_____ | ❑ Social Security $_____ ❑ Pension $_____ |
| ❑ Alimony $_____ ❑ Unemployment $_____ | ❑ Alimony $_____ ❑ Unemployment $_____ |
| ❑ Disability $_____ ❑ Commission $_____ | ❑ Disability $_____ ❑ Commission $_____ |
| ❑ Tips $_____ ❑ Child Support $_____ | ❑ Tips $_____ ❑ Child Support $_____ |
| ❑ Rental Income $_____ ❑ Investments $_____ | ❑ Rental Income $_____ ❑ Investments $_____ |
| ❑ Public Assist $_____ ❑ Child Care $_____ | ❑ Public Assist $_____ ❑ Child Care $_____ |
| ❑ Workman's Compensation $_____ | ❑ Workman's Compensation $_____ |
| ❑ Other _____ | ❑ Other _____ |
| **Total Income per month (include wages)** $_____ | **Total Income per month (include wages)** $_____ |

List dependents claimed on Income Tax Return (Other than self or spouse)

| Dependents Name | Date of Birth | Relationship to Responsible Party |
|---|---|---|
| | | |
| | | |
| | | |

Assets

| | | | | | |
|---|---|---|---|---|---|
| Checking account #1 balance | $_____ | Checking account #2 balance | $_____ | Name of Bank _____ | |
| Savings account #1 balance | $_____ | Savings account #2 balance | $_____ | Name of Bank _____ | |
| Value of Stocks | $_____ | Value of bonds | $_____ | Value of whole life insurance | $_____ |
| Value of certificate of deposit | $_____ | Value of IRA #1 | $_____ | Value of IRA #2 | $_____ |
| Value of mutual funds | $_____ | Value of annuities | $_____ | | |
| Assessed value of home #1 | $_____ | Assessed value of home #2 | $_____ | Other property _____ | $_____ |

## Transporation

Vehicle #1 year/model _____/_____ Payment $_____/mo Balance $_____ Gas $_____/mo Insurance $_____/mo
Vehicle #2 year/model _____/_____ Payment $_____/mo Balance $_____ Gas $_____/mo Insurance $_____/mo
Vehicle #3 year/model _____/_____ Payment $_____/mo Balance $_____ Gas $_____/mo Insurance $_____/mo
Motorcycle year/model _____/_____ Payment $_____/mo Balance $_____ Gas $_____/mo Insurance $_____/mo
Boat year/model _____/_____ Payment $_____/mo Balance $_____ Gas $_____/mo Insurance $_____/mo
Snowmobile year/model _____/_____ Payment $_____/mo Balance $_____ Gas $_____/mo Insurance $_____/mo
Trailers/Motor homes _____/_____ Payment $_____/mo Balance $_____ Gas $_____/mo Insurance $_____/mo
RV, ATV, SUV _____/_____ Payment $_____/mo Balance $_____ Gas $_____/mo Insurance $_____/mo
Monthly fare: Bus $_____ Taxi $_____

## Household Expenses

| | | | | | |
|---|---|---|---|---|---|
| ❑ House payment | $_____/mo | ❑ Rent | $_____/mo | ❑ House/Rental insurance | $_____/mo |
| ❑ Property taxes (year) | $_____/mo | ❑ Gas/Propane | $_____/mo | ❑ Electric | $_____/mo |
| ❑ Water | $_____/mo | ❑ Phone | $_____/mo | ❑ Cell phone | $_____/mo |
| ❑ Cable/Dish/Internet | $_____/mo | ❑ Trash Removal | $_____/mo | ❑ Groceries | $_____/mo |
| ❑ Childcare/Child support | $_____/mo | ❑ Clothing | $_____/mo | ❑ Tuition | $_____/mo |
| ❑ Health Insurance | $_____/mo | ❑ Life insurance | $_____/mo | ❑ Other_____ | $_____/mo |

## Credit Card/Loan Payments

Name of lender/card _____ Payment $_____ Balance $_____
Name of lender/card _____ Payment $_____ Balance $_____
Name of lender/card _____ Payment $_____ Balance $_____
Name of lender/card _____ Payment $_____ Balance $_____
Name of lender/card _____ Payment $_____ Balance $_____

## Out of Pocket Medical and Pharmacy

Name of provider or prescription _____ Payment $_____ Balance $_____
Name of provider or prescription _____ Payment $_____ Balance $_____
Name of provider or prescription _____ Payment $_____ Balance $_____
Name of provider or prescription _____ Payment $_____ Balance $_____
Name of provider or prescription _____ Payment $_____ Balance $_____

Were you denied by the state for Medicaid assistance due to excess assets ❑ Yes ❑ No

If yes, please explain these assets _____

_____

_____

I understand that the information which I submitted is subject to verification by the hospital and subject to review by Federal and/or State enforcement agencies and others as required. I understand that a credit report may be requested and reviewed as required. I certify that the above information is true and correct.

_____ _____
Applicant Signature or Patient Representative Date

_____ _____
Applicant's Spouse/Partner Signature Date

**Attach Copies Of:**
_____ Last three months pay stubs/unemployment
_____ Last three months bank statements
_____ Latest tax return
_____ Proof of citizenship/residency
_____ Medicaid Denial (if applied)
_____ No income **(If no income, a letter from the person supporting you including relationship.)**

Return to: _____
Lakeland HealthCare
P.O. Box 410
St. Joseph, MI 49085
Attn.: Patient Accounts