Roosevelt General Hospital

Patient: _____ M/R No: _____ DOB: _____ Admit Date: _____ Disch. Date: _____

Responsible Party	Age	Social Security No	Spouse	No of children and other dependents as defined by I.R.S. and claimed as exemptions	No Ages

Address Zip Code	How Long	Former address if less than 2 years at present address	How Long	Time in area	Telephone No

Employer of Responsible Party Phone No.	Position	How Long Employed	Pay Day	Monthly Gross income	Take Home Pay Each Pay Day	Take Home Pay Monthly
				$	$	$
Employer of Spouse Phone No.	Position	How Long Employed	Pay Day	$	$	$

If Unemployed-For how long and who was previous employer

Other Source of Income:
___ Alimoney ___Interest ___Food Stamps ___Retirement ___Workers Comp ___Other( )
___Child Support ___Rent ___Public Assistance ___Social Security ___Unemployment

Bank _____ Checking Acct Balance $_____ Savings Acct Balance $_____ Monthly Take Home Pay (A) $_____

	Name of Creditor	Balance	Monthly Pymt
CAR Make/Year		$	$
CAR Make/Year		$	$

Rent □ Trailer House □ Apartment □

Own □ Home □

Name of Creditor		Balance	Monthly Pymt
Mastercard - C.C.	Limit		
Visa - C.C.	Limit	$	$
Other Hospitals		$	$
Medical		$	$
Other		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
	Totals	$	(03)

01 Rent/Paid To: _____ $_____

02 Energy and Utilities

Water $_____ Gas _____

Electric $_____ Telephone $_____ Car Gas $_____

(Total of 01 & 02) House & Energy Payments (B) $_____

(Total of 03) Monthly Paymer nts (C) $_____

Totals Line B & C (D) $_____

Line A Minus D $_____

Gross Annual Family Income $_____

Number in Family _____

Federal Guidelines $_____

Name, Address and Telephone Number of a Relative or Friend Other Than That Used Above:

Relationship

I understand that the information submitted is subjest to verification by Roosevelt General Hospital. I certify that the above information is true and cao and correct to the best of my knowledge. If any information given proves to be untrue, I understand that RGH may take whatever action necessary.

Charity Application Approved by James Ybarra on _____.
Meets requirements, income, debt overload, catastrophic medical or expired and left no estate. _____
James Ybarra/Business Office Director

_____ Date

_____ Signature of Applicant

_____ Witness

Information Verified YES _____ NO _____

Additional Information (Hospital Use Only)

Credit Report YES _____ NO _____

Reason for Approval

1. Income Guidelines Met _____
2. Unemployed _____
3. Debt Overload _____
4. Catastrophic Med Bills _____
5. Expired/No Estate _____
6. Other _____

_____

Financial Arrangements Made

$_____ For _____ Months Beginning _____

Billed Charges $ _____

3rd Party Pymts $ _____

Balance $_____

_____ _____

DATE SIGNATURE OF PERSON TAKING APPLICATION

Roosevelt General Hospital
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P.O. Drawer 868
Portales, NM 88130
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