

Granville Health System
Confidential Financial Analysis Worksheet

Dear Patient/Guarantor:

GMC is committed to working with patients to resolve unpaid accounts. However, we need your cooperation to assist you. The information below is utilized by our Business Office to determine your qualification for our Medical Assistance Program or the establishment of a payment plan for unpaid account balances.

If you have any questions or would like our assistance in completing this form, please feel free to contact us at 919/690-3267.

Thank you for choosing Granville Medical Center for your healthcare needs. We are honored to have had the pleasure to serve you.

GUARANTOR INFORMATION	<i>NAME</i>		<i>DATE OF BIRTH</i>	<i>HOME ADDRESS</i>	<i>HOME TELEPHONE</i>
	<i>EMPLOYER'S NAME</i>		<i>EMPLOYER'S PHONE</i>	<i>OCCUPATION/TITLE</i>	<i>SOCIAL SECURITY NUMBER</i>
SPOUSE'S INFORMATION	<i>NAME</i>		<i>DATE OF BIRTH</i>	<i>HOME ADDRESS</i>	<i>HOME TELEPHONE</i>
	<i>EMPLOYER'S NAME</i>		<i>EMPLOYER'S PHONE</i>	<i>OCCUPATION/TITLE</i>	<i>SOCIAL SECURITY NUMBER</i>
OTHER DEPENDENT INFORMATION	<i>NAME</i>	<i>RELATION TO PATIENT</i>	<i>AGE</i>	<i>SOCIAL SECURITY NUMBER</i>	

INCOME				
INCOME – Monthly		DEDUCTIONS		
<i>Gross Salary</i>		<i>Federal</i>		
<i>Spouse's Gross Salary</i>		<i>State</i>		
<i>Dividends and Interest</i>		<i>Medicare</i>		
<i>Rental Income</i>		<i>Social Security</i>		
<i>Pension Income</i>		<i>Total Taxes/Deductions</i>		
<i>Self Employment Income</i>				
<i>Unemployment Benefits</i>				
<i>Child Support/Alimony</i>				
<i>Other – Please List</i>				

ASSETS							
CHECKING ACCOUNT(S)	Name and Location of Bank		Account Balance	SAVINGS ACCOUNT(S)	Name and Location of Bank		Account Balance
IRA OR 401 K PLAN							
CERTIFICATES OF DEPOSIT (CD's)							
STOCK AND BONDS							

OTHER	'	VALUE	BALANCE	NUMBER OF REMAINING	OTHER ASSETS/PAYMENTS	'	VALUE	BALANCE	NUMBER OF REMAINING
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<i>ASSETS/PAYMENTS</i>		<i>OWED</i>	<i>PAYMENTS</i>			<i>OWED</i>	<i>PAYMENTS</i>
HOME VALUE				CAR 1			
RENTAL PROPERTIES				CAR 2			
OTHER REAL ESTATE				CREDIT CARDS			
OTHER PROPERTY (Boats, Campers, etc)				OTHER			

I understand that by completing this application, I am requesting the Granville Medical Center provide me with extended payment arrangements and as such, authorize Granville Medical Center to verify any information provided on this form, as well as verification of my credit information by means of inquiry with a credit reporting agency. I further certify that all information that I have provided is accurate and that failure to provide accurate and truthful information may result in my application being denied.

GUARANTOR/PATIENT'S SIGNATURE	DATE	WITNESSED BY	DATE