



St. Luke's Hospital

101 Hospital Drive Columbus, N.C. 28722

(828) 894-0912

COMPLETED FORM AND ALL INFORMATION REQUESTED MUST BE RETURNED TEN DAYS FROM DATE YOU RECEIVE APPLICATION OR THE APPLICATION WILL BE VOID

PAGE 2. Read, Sign and Date at bottom of page.

PAGE 3. Complete all requested information on this page that applies to you. If it does not apply to you, please indicate by entering NA in blank

PAGE 4. Complete all requested information, if the question does not apply to you, please indicate by entering NA in blank.

See income verification information below and include the information that applies to you. All family income information is needed.

- Complete Previous Years Federal Tax Return with W2's and All schedules.**
- Social Security Statement (yearly statement or bank statement to verify)**

If you did not file taxes or did not have income the prior year, call us to discuss the information you will need to supply for verification of income.

- Copy of your most current County Tax notice (if you are a homeowner)**
- Copy of most current County Tax notice, if you have a 2nd property**
- Copy of current month 1st Home Mortgage Statement.**
- Copy of current month 2nd Home Mortgage Statement.**
- Current statement for all Checking, Savings, and CD's.**
- Current statement for any investments such as stocks, bonds, IRA's, etc.**

**FINANCIAL DISCLOSURE FORM/APPLICATION FOR COMMUNITY CARE
ST LUKE'S HOSPITAL**

Patient Name: _____ Social Sec.# _____ Birth Date: _____

Address: _____ City/State/Zip: _____ Phone#: _____

Employer: _____ Phone#: _____
(COMPLETE BUSINESS NAME, ADDRESS AND PHONE NUMBER)

Length of Employment: _____ Occupation: _____

Responsible Party/Guarantor if other than Patient:

Name: _____ Relationship: _____ Social Sec.#: _____

Address: _____ City/State/Zip: _____ Phone#: _____

Employer: _____ Phone#: _____
(COMPLETE BUSINESS NAME, ADDRESS & PHONE NUMBER)

Length of Employment: _____ Occupation: _____

Spouse: _____ Social Sec.#: _____ Birth Date: _____

Address: _____ City/State/Zip: _____ Phone#: _____

Employer: _____ Phone#: _____
(COMPLETE BUSINESS NAME, ADDRESS AND PHONE NUMBER)

Length of Employment: _____ Occupation: _____

Dependents (Name and Relationship)

Name	Date of Birth	Age	Relationship

INCOME: Represents total cash receipts for all sources before taxes including, but not limited to: wages, public assistance, payments, social security, unemployment or workers compensation benefits, union strike pay, VA benefits, child support, alimony, pension, income insurance, annuity payments, interest rental income, royalties, estate or trust income, tax refunds and compensation for injury claims. Income is to be stated on a gross earnings/receipts basis. Calculations are based on total family income.

SOURCE OF INCOME:				
PATIENT NAME	MONTHLY INCOME	SPOUSE NAME	MONTHLY INCOME	OTHER INCOME

Payroll deductions: \$ _____
 (i.e. UNION DUES, INSURANCE PREMIUMS, GARNISHMENTS, PRE-TAX, ETC.)

TYPE	LOCATION	AMOUNT	TYPE	LOCATION	AMOUNT
CHECKING			CD'S/IRA'S		
SAVINGS			OTHER		

ASSETS - AUTO OR TRUCKS

MAKE/MODEL/YEAR		EST. VALUE:		LOAN BALANCE:	
MAKE/MODEL/YEAR		EST. VALUE:		LOAN BALANCE:	

OTHER ASSETS - RECREATIONAL VEHICLES

TYPE	ESTIMATED VALUE	LOAN BALANCE
MOTORCYCLE		
BOAT/MOTOR		
MOTORHOME/R.V.		

EST. REGULAR MONTHLY EXPENSES STATED ON MINIMUM MONTHLY PAYMENT BASIS

Type	Payment	Balance	Type	Payment	Balance
1. 1st Mortgage			7. Insurance Premium		
2. 2nd Mortgage			8. Continuous Medication		
3. Rent			9. Medical Debt (Specify)		
4. Food			10. Medical Debt (Specify)		
5. Utilities			11. Other		
6. Transportation/Gas			12. Other (Specify)		