APPENDIX A

CAPITAL HEALTH
CONFIDENTIAL FINANCIAL WORKSHEET

DATE OF SERVICE _____

PATIENT NAME _____

ADDRESS: _____
_____

PHONE: _____

RESPONSIBLE PARTY_____

ADDRESS: _____
_____

PLACE OF EMPLOYMENT

PATIENT:_____

PARENT/SPOUSE: _____

PARENT/SPOUSE: _____

FAMILY SIZE

NUMBER IN HOUSEHOLD: _____

OTHER DEPENDENTS:_____

MONTHLY INCOME (FOR DATE OF SERVICE ONLY)

PATIENT'S INCOME _____

SPOUSE'S INCOME _____

FATHER'S INCOME (IF PT IS A MINOR)_____

MOTHER'S INCOME (IF PT IS A MINOR) _____

CHILD SUPPORT _____

SOCIAL SECURITY _____

PENSION _____

SSI/DISABILITY _____

FOOD STAMPS_____

OTHER INCOME
( ) YES _____
( ) NO _____

TOTAL MONTHLY INCOME _____

I certify that the above information is true and accurate and that this application is made to enable Capital Health to judge my eligibility for reduced out-of-pocket medical expenses. If any of the information that I have given proves to be untrue, I understand that Capital Health may re-evaluate my financial status and take action necessary to collect on my account.

PATIENT, PARENT OR LEGAL GUARDIAN:

_____	_____	_____
(Print Name)	(Signature)	(Date)