

Mary Washington Healthcare

Financial Statement

Date:
Patient:
Account No.

The information on this form is requested so that we can give full consideration to your request for credit through an extended payment arrangement. This information will be kept confidential and may be used to assist you in receiving financial assistance. Please complete the entire form and return it within ten days. Thank you.

PERSONAL INFORMATION:

APPLICANT	C0-APPLICANT
Name:	Name:
Address:	Address:
Home #:	Home #:
SS#:	SS#:
Employer:	Employer:
Address:	Address:
Work #:	Work #:
Ages of Minor Children	Ages of Minor Children

GROSS MONTHLY INCOME:*

APPLICANT	C0-APPLICANT
Salary & Commissions:	Salary & Commissions:
Disability:	Disability:
Social Security:	Social Security:
Unemployment:	Unemployment:
Child Support:	Child Support:
Other Income:	Other Income:
Total Gross Income:	Total Gross Income:

MONTHLY EXPENSES:

BANKING INFORMATION:

Rent/Mortgage	Checking Account #
Utilities	Balance
Loan Payments	Bank
Car Payments	
Food	Savings Account #
Child Care	Balance
Insurances	Bank
Medical	
Credit Cards	Other Account#
Other Expenses (Please list):	Balance
	Bank
Total Monthly Expenses:	

** Please attach pay stubs and last years income tax return.

AUTO INFORMATION:**REAL ESTATE INFORMATION:**

Make & Model:	Location:
Year:	Mortgage Holder:
Lienholder:	Assessed Value:
Balance Due on Loan:	Unpaid Mortgage Balance:
	Total Equity:
Make & Model:	
Year:	Location:
Lienholder:	Mortgage Holder:
Balance Due on Loan:	Assessed Value:
	Unpaid Mortgage Balance:
Make & Model:	Total Equity:
Year:	
Lienholder:	
Balance Due on Loan:	

My signature below indicates that the above information is true and correct to the best of my knowledge.

Applicant

Date:

Co-Applicant

Date:

***** Do Not Write Below This Line - For Office Use Only *****

Account Balance:	CBR Attached
Terms Agreed Upon:	Annual Household Income:
Payments Remaining:	Family Size:
Account Rep:	
Approved By:	Rejected By:
Date:	Reason: