DIVINE SAVIOR HEALTHCARE
COMMUNITY CARE APPLICATION

Responsible Party ________________________________ DOB__________ Telephone________________

Address ____

Marital Status (Circle One) married single divorced Home phone/cell phone ______________________

Employment Status (Circle One) student employed unemployed disabled retired

Employer/School name and address ____

Occupation _________________________________ Length of Employment _______________________

Patient Name _______________________________ DOB _________________

Balance owed: DSH Hospital $__________________________ Acct # ___________________

DSH Clinic $ ___________________________ Acct # ___________________

DSH Extended Care $ ____________________ Acct # ___________________

Spouse's Name ______________________________________ DOB ____________________________

Spouse employment status (circle one) Student Employed Unemployed Disabled Retired

Spouse's Employers/School name & address ____

Number of dependents ________________ Ages ____

Monthly Expenses as listed on Page 2 (see reverse) $_________________________

Checking Account Balance $ _______________________ as of _____________________

Savings Account Balance $ _______________________ as of _____________________

Total value of Pensions, 401Ks, stocks, bonds and other investments $ __________________________

Do you own your home? _________ Approx Value $ _______________ Bal owed $ _________________

Do you own any other property? _________ Approx Value $ ______________ Bal owed $ _____________

Auto/truck (make and year) __________________________________ Value $______________
Balance owed $ _____________________

Auto/truck (make and year) __________________________________ Value $ _____________
Balance owed $ _____________________

Other assets (describe) _______________________________ Value $__________ Bal $______________

I (We) certify that all information given is complete and accurate to the best of my (our) knowledge.

_______________________________ __________ ___________________________ _____________
Signature Date 2nd Pty Signature Date

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Monthly Household expenses:

Debt	**Monthly Payment**	**Total Balance of Acct**
Mortgage/Rent	$ ______________	$ ______________
Health Insurance	$ ______________	$ ______________
Home Equity Loan	$ ______________	$ ______________
Auto/truck Loan	$ ______________	$ ______________
Auto/truck Loan	$ ______________	$ ______________
Credit Card	$ ______________	$ ______________
Credit Card	$ ______________	$ ______________
Credit Card	$ ______________	$ ______________
Medical/dental	$ ______________	$ ______________
Medical/dental	$ ______________	$ ______________
Daycare	$ ______________	$ ______________
Telephone	$ ______________	$ ______________
Water/gas	$ ______________	$ ______________
Electric	$ ______________	$ ______________
Heat	$ ______________	$ ______________
Cable/satellite TV	$ ______________	$ ______________
Food	$ ______________	$ ______________
Prescription Medications	$ ______________	$ ______________
Child Support	$ ______________	$ ______________
Other	$ ______________	$ ______________
Total	$ ______________	

Notes or special circumstances: ____

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