Granville Health System
Confidential Financial Analysis Worksheet

Dear Patient/Guarantor: Account Number _____

GHS 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 Financial 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 919-690-3239.

Thank you for choosing Granville Health System for your healthcare needs.

GUARANTOR INFORMATION	***NAME***		***DATE OF BIRTH***	***HOME TELEPHONE***
	ADDRESS			***COUNTY***
	EMPLOYER'S NAME	***EMPLOYER'S PHONE***	***OCCUPATION/TITLE***	***SOCIAL SECURITY #***
SPOUSE'S INFORMATION	***NAME***		***DATE OF BIRTH***	***HOME TELEPHONE***
	ADDRESS			***COUNTY***
	EMPLOYER'S NAME	***EMPLOYER'S PHONE***	***OCCUPATION/TITLE***	***SOCIAL SECURITY #***

OTHER DEPENDENT INFORMATION	***NAME***	***RELATION TO PATIENT***	***AGE***

INCOME

Gross Salary		**FOR OFFICE USE ONLY**
Spouse's Gross Salary		
Dividends and Interest		
Rental Income		
Social Security/Pension/Disability Income		
Self Employment Income		
Unemployment Benefits		
Child Support/Alimony		
Other – Please List		
TOTAL MONTHLY INCOME		

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)					
STOCKS AND BONDS					

OTHER ASSETS/PAYMENTS	*VALUE*	*BALANCE OWED*	*PAYMENTS*	*OTHER ASSETS/PAYMENTS*			
HOME VALUE				**VEHICLE 1**	**Year**	**Make**	**Model**
				PAYMENTS	**VALUE**		**BALANCE OWED**
				VEHICLE 2	**Year**	**Make**	**Model**
				PAYMENTS	**VALUE**		**BALANCE OWED**
OTHER REAL ESTATE				**ADDRESS**			**COUNTY**

MONTHLY HOUSEHOLD EXPENSES **Please list monthly household expenses**	**CREDIT CARDS**	**PAYMENTS**	**BALANCE OWED**
	LOANS	**PAYMENTS**	**BALANCE OWED**
	TOTAL MONTHLY HOUSEHOLD EXPENSES		

I understand that by completing this application, I am requesting the Granville Health System provide me with extended payment arrangements and as such, authorize Granville Health System 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**
SPOUSE SIGNATURE	**DATE**