Granville Health System
Confidential Financial Analysis Worksheet

Dear Patient/Guarantor: Account Number _______________

GMC 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 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 Medical Center 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

		FOR OFFICE USE ONLY
Gross Salary		
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 Medical Center provide me with extended payment arrangements and as such, authorize Granville Medical Center 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**