Perham Health
SANFORD

Attn: Patient Account Services

Return To:
Perham Health
1000 Coney Street W
(218) 347-4500

| Date | Patient Name |
|---|---|
| History | Date of Service |

**Demographic Information**

| Name | Date of Birth | Spouse | Date of Birth |
|---|---|---|---|
| Address | | City / State | Zip Code |
| Time at present address: _____ Years _____ Months | Rent ☐ Own ☐ | County | ☐ Township ☐ Village ☐ City of _____ |
| Telephone: ( ) | Number fo household members | Ages of household members | |

| | Self | Spouse |
|---|---|---|
| Employed by | | |
| Business address | | |
| Business phone | ( ) | ( ) |
| Occupation / Hourly Wage $ | | / Hourly wage $ |
| How Long Employed / Hours worked/wk: | | / Hours worked/wk: |
| Social Security Number | | |

**Source of Income**

**Income:** Represents total cash receipts from all sources before taxes.

| | Self | Monthly Gross | Spouse | Monthly Gross |
|---|---|---|---|---|
| Gross income | | | | |
| Social security | | | | |
| Public assistance | | | | |
| Interest dividends | | | | |
| Rental income | | | | |
| Retirement/pension | | | | |
| Veterans benefits | | | | |
| Unemp/Work Comp | From: To: | | From: To: | |
| Child support | From: To: | | From: To: | |
| Foster care | | | | |
| Disability | | | | |
| Other/identity | | | | |
| | **TOTAL $** | | **TOTAL $** | |

**Combined monthly gross income $** | **Combined yearly gross income $**

**Assests\Savings(Joint)**

| | Location | Amount/Value |
|---|---|---|
| Checking | | |
| Savings | | |
| Cert. of Deposit (CD) | | |
| Stocks/bonds | | |
| Other | | |

# Community Care Application

**Assets / Property**

| | | | | |
|---|---|---|---|---|
| **Motor Vehicle** | Year/make/model | Value | Loan Balance | Lien holder |
| | Year/make/model | Value | Loan Balance | Lien holder |
| **Recreational Equipment (boats, snowmobiles, etc).** | Year/make/model | Value | Loan Balance | Lien holder |
| | Year/make/model | Value | Loan Balance | Lien holder |
| **Other Property** | Address, township,county | | Loan Balance | Assessed Value |
| | Address, township,county | | Loan Balance | Assessed Value |
| **Homestead** | Address | | | Assessed Value |
| | Township, county | | Mortgage balance | Lien holder |

**Monthly Expenses**

| | | | |
|---|---|---|---|
| Mortage or rent | Renter's/house insurance | Motor vehicle payment | Cable TV/satellite |
| Phone | Transportation cost | Child support | Child care |
| Electric | Auto insurance | Food | |
| Heat | Life insurance | Property taxes | Other/specify |
| Water & sewer | Health insurance | Medications | **TOTAL $** |

**Credit Cards/Other Expneses**

| Creditor Name | Address | Balance | Monthly Payment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | **TOTAL $** | |
| **GRAND TOTAL/CREDIT CARDS, OTHER EXPENSES, AND MONTHLY EXPENSES** | | | **$** |

**Public Assistance**

I (have) or (will) be applying for assistance in

_____ County, _____ State.

Please enclose a copy of your letter of denial from Medical Assistance if applicable.

Complete and return this Financial Statement, along with the following:

- Copy of your last 2 year's Federal Tax Returns
- Copy of your last year's Property Tax Statement
- Copy of your most recent pay stub
- Copy of your most recent bank statment

All informtaion requested must be completed. Incomplete applications will be returned to the sender. The information received on this Financial Statement is confidential and is for review of your immediate situation.

I/We hereby certify the above information is correct and voluntarily authorize you to obtain credit information relative to me/us.

_____ _____

Signature Date Signature Date