



Caring is our Reason for Being

400 East First Street • Morris, MN 56267 • 320-589-1313 • www.scmcinc.org

## STEVENS COMMUNITY CARE EXPENSE REPORT

The information disclosed below will only be used to determine your ability to make monthly payments on your account. It is not a pre-requisite to receiving health care nor will it be disclosed to other creditors or anyone requesting financial data.

Name: \_\_\_\_\_

Spouse: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Family Size \_\_\_\_\_

Your Employer: \_\_\_\_\_ Avg. Hours Per Week \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Avg. Hours Per Week \_\_\_\_\_

MO Gross Income: Yours: \_\_\_\_\_ Spouse: \_\_\_\_\_ Other: \_\_\_\_\_ Total: \$ \_\_\_\_\_

### Monthly Expenses:

Rent/Mortgage PMNT	\$ _____	Sewer, Water, Garbage	\$ _____
Home Taxes/Insur	\$ _____	Gasoline	\$ _____
Electricity	\$ _____	Daycare	\$ _____
Heat	\$ _____	Groceries	\$ _____
Insurance, Car	\$ _____	Telephone	\$ _____
Insurance, Health	\$ _____		
Insurance, Life	\$ _____		Balance Owing:
Bank Loans	\$ _____		\$ _____
Bank Loans	\$ _____		\$ _____
Charge Account: _____	\$ _____		\$ _____
Charge Account: _____	\$ _____		\$ _____
Charge Account: _____	\$ _____		\$ _____
Stevens Community Medical Center	\$ _____		\$ _____
Medical: _____	\$ _____		\$ _____
Medical: _____	\$ _____		\$ _____
Medical: _____	\$ _____		\$ _____
Other: _____	\$ _____		\$ _____
Other: _____	\$ _____		\$ _____

Total Gross Income: \$ \_\_\_\_\_ Total Expenses: \$ \_\_\_\_\_ Difference: \$ \_\_\_\_\_

I verify that the above is true and correct to the best of my knowledge.

Applicant signature: \_\_\_\_\_

### TO BE COMPLETED BY STEVENS COMMUNITY MEDICAL CENTER PATIENT ACCOUNT SERVICES.

Recommendations: \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_