STEVENS COMMUNITY MEDICAL CENTER
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: _____

Routing: Given to patient to fill out → bo29 (11-17) rev 1-18
Patient Account Services retains for 1 year → scans into EDM → shred