



To Whom Owed	Monthly Expenses Balance	Monthly Payment
Rent/Mortgage		
Auto #1		
Auto #2		
Credit Card #1		
Credit Card #2		
Medical Bill		
Medical Bill		
Medical Bill		
Medical Bill		
Food _____ Utilities _____ Phone _____ Water _____ Cable _____		
Heating Fuel _____ Medicine _____ Child Care _____ Transportation/Gas _____		
Health Ins (not deducted from check) _____ Life Ins (not deducted from check) _____		
Homeowner's Ins _____ Auto Ins _____		

Attach a separate sheet for additional expenses not listed above.

**Authorization**

I/We authorize Halifax Regional Hospital to verify all information contained in this financial statement. Everything on this financial statement is correct to the best of my knowledge.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE. FOR HOSPITAL USE ONLY.**

Total Monthly Income: \$ _____	Recommendation for Charity:
Total Monthly Expenses: \$ _____	\$ _____ X 12=\$ _____
Disposable Monthly Income: \$ _____	Meets Income Approved: _____
	Trust (CFS) 100% _____
	Non-Trust 100% _____
	Non-Trust 75% _____
	Non-Trust 50% _____
	Non-Trust 25% _____
Patient Financial Representative _____	Over Income: _____
	Medically Indigent _____
	20% _____
	15% _____

#PFS05#

Form # PFS05

**Financial Statement**