HEART OF AMERICA
MEDICAL CENTER

Heart of America Medical Center
2975 Highway 2 East
Rugby, ND 58368
(701) 776-5261

Living Center Financial Assessment

Date of Request: _____

Demographic/Financial Statement

1. Name: _____
   First *Middle* *Last*
   Address: _____
   Number & Street *City* *State* *Zip Code*
   Date of Birth:_____ Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced
   Home Phone: _____ Cell Phone: _____
2. Spouse Name (if applicable):_____
3. POA, (Please provide paperwork): _____

Financial and asset questionnaire: All numbers for a MONTHLY period

Wage Income _____

Social Security Income _____

Pension Income _____

Income from Dividends _____

Interest Income _____

Rental Income _____

Money Market _____

Land & Acres & Value _____

House & Value _____

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Financial Resources:

Bank Account(s)/CD's/Stocks/Bonds

Bank	_____	Account Number	_____	Balance	_____
Bank	_____	Account Number	_____	Balance	_____
Bank	_____	Account Number	_____	Balance	_____
Bank	_____	Account Number	_____	Balance	_____

Average Total Balance for Previous Six Months _____

Bank	_____	Cert of Deposit #	_____	Value	_____
Bank	_____	Cert of Deposit #	_____	Value	_____
Bank	_____	Cert of Deposit #	_____	Value	_____
Bank	_____	Cert of Deposit #	_____	Value	_____

Institution _____ Money Market Certificate _____ Value _____

Other Acccount

_____

Stocks and Bonds Value: _____

Long Term Care Insurance: _____

If Patient has Medicaid of will be applying for in the future, who will be assisting them for yearly renewal of Medicaid or will assist with applying for Medicaid: _____

Medicaid Identification Number: _____

I affirm that the information listed in this Request is true and correct to the best of my knowledge. I Hereby authorize Heart of America Medical Center to contact any of the above institutions with the express intention of verifying the information provided.

_____ _____

Signature (Person Making Request) Date