

**GEISINGER HEALTH SYSTEM
FINANCIAL STATEMENT**

Date: _____

Guarantor's Name: _____ Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

How Long at this Address? _____ No. of Children under 18: _____ Date of Birth: _____

Marital Status: Married _____ Divorced _____ Widowed _____ Single _____ Separated _____

Place of Employment: _____ How Long Employed: _____

Position: _____

Gross Salary (Monthly): \$ _____ Net Salary (Monthly): \$ _____

Spouse's Name: _____ Spouse's Social Security No.: _____

Place of Employment: _____ Position: _____

Gross Salary (Monthly): \$ _____ Net Salary (Monthly): \$ _____

Additional Income: Social Security _____ Pension _____ Disability _____ Other (Specify) _____

Total Amount of Additional Income (Monthly) \$ _____

Credit Union Name: _____ Share Balance: \$ _____ Loan Balance: \$ _____

Bank Account (Where): _____ Checking Bal.: \$ _____ Saving Bal.: \$ _____

HOME: Own _____ Mortgage Holder: _____ Monthly Payment: \$ _____

Market Value: \$ _____ Mortgage Balance: \$ _____ Original amount: \$ _____

Rent _____ Landlord's Name: _____ Monthly Payment: \$ _____

CARS: Own _____ Financed _____ Financed With: _____

Monthly payment: \$ 1. _____ 2. _____ Balance Due: \$ 1. _____ 2. _____

Year and Make of Car(s): 1. _____ 2. _____

MONTHLY EXPENSES: \$ _____ Telephone \$ _____ Food \$ _____ Cable

\$ _____ Heat \$ _____ Water/Sewer \$ _____ Working Expenses

\$ _____ Electric \$ _____ Property Taxes \$ _____ Other (Specify)

INSURANCE PAYMENT: Life: \$ _____ Health: \$ _____ Auto.: \$ _____

OUTSTANDING DEBTS WITH BANKS, DEPARTMENT STORES, OR OTHER FINANCIAL INSTITUTIONS

Name and Address of Creditor	Original Balance	Monthly Payment	Balance Due
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____
(3) _____	_____	_____	_____
(4) _____	_____	_____	_____

Total Monthly Payments \$ _____

I Certify to the truth of the above statement, I also hereby authorize Geisinger to investigate the references herein listed or statements or other data obtained from me or from any other person pertaining to my credit and financial responsibility.

Date: _____ Signature _____

Person assuming responsibility for account of _____

(Patient)

Account No. _____ Employee's Initials: _____