

Catahoula Parish Hospital District #2

Patient Household Financial Information

Name:							
Total gross annual salary							
(Attach copies of latest check stubs) 2. Place of Employment:							
Place indicate	e which o	f the	following n	nay apply to you and the g	iven an	nounts	
	Do	you o	r anyone in	your family receive:			
	YES	NO	AMOUNT		YES	NO	AMOUNT
A. Social security				M. Any regular support			
B. Unemployment				from someone not			
				living with you			
C. Workman's comp.				N. Government employee			
D. Strike benefits				pension			
E. Veteran's benefits							
F. Job training funds				O. Private insurance and/			
G. Alimony				or regular insurance			
H. Child support				or annuity payments			
I. Military family				P. Dividends			
allotments				Q. Interest Payments			
J. AFDC				R. Rental Payments			
K. Social Security for				S. Royalties			
spouse, children				T. Income from estate and/			
or others				or trusts			
L. Food stamps				TOTAL GROS	SS INCO	ME:	
		gross in	come is conside	e and that all of the information suppered an act of fraud and can be punishing to federal law.			
Spouse Signature				Signed			

Date:		Family ID #:			
Name of head of household:		Payment Coc	le:		
Address:	Race:				
Family Members	Sex	Date of Birth	Relationship		
FO!	R OFFICE	USE ONLY			
Today's date:		Expiration date:			
Date updated:					
Witnessed by:					