Faulkton Area Medical Center
1300 Oak Street PO Box 100
Faulkton, SD 57438
605/598-6262

FINANCIAL STATEMENT FOR_____
Date of Birth: _____ Spouse's Name/Date of Birth: _____
Ages and names of dependent children_____
_____

		ASSETS	Wife	Husband
Cash in Bank	_____	Monthly Gross Income	_____	_____
Cash on Hand	_____	Veterans Pension	_____	_____
Stocks & Bonds	_____	Disability Pension	_____	_____
Vehicles:		Retirement (all)	_____	_____
Year ___ Type _____ Value _____		Social Security	_____	_____
___ _____ _____		Public Assistance	_____	_____
Home: # Rooms _____		Unemployment	_____	_____
Purchase Price	_____	Workmens Comp.	_____	_____
Improvements	_____	Union Benefits	_____	_____
Est. Value Now	_____	Alimony/Child Supp	_____	_____
Other Real Estate	_____	Disability Pay	_____	_____
Farm Equipment	_____	Stock/Bond Revenue	_____	_____
Livestock	_____	Inheritance	_____	_____
Rental Property	_____	Strike Benefits	_____	_____
Business	_____	Interest Income	_____	_____
Inheritance pending	_____	Military Allotment	_____	_____
Other Investments-savings: (list)		Monthly Rental Income	_____	_____
_____		Other (List)	_____	_____
Cash Value of Life Insurance	_____			
Furniture/Appliances	_____			
# of Farm Acres	_____			
		Total Gross Income	_____	_____
		Combined Income	_____	

Name of Creditor	Unpaid Balance	Monthly Pmts.	Monthly Expenses not previously listed	
Bank Loan	_____	_____	Rent	_____
Auto Loan	_____	_____	Food	_____
Credit Union	_____	_____	Insurance	_____
Charge Cards	_____	_____	Insurance	_____
Doctors/Dentist	_____	_____	Clothing	_____
Hospitals	_____	_____	Phone	_____
Collection Agencies	_____	_____	Utilities	_____
Other	_____	_____	Car Exp (not pmts)	_____
Total Monthly pmts		_____	Other (explain)	_____
Husband Employer	_____		_____	
Wife Employer	_____		Total	_____

Remarks:_____
_____
State your proposed repayment plan:_____

I hereby acknowledge that the information given to Faulkton Area Medical Center above is true and correct and given for the purpose of obtaining credit, and I (we) authorize release of this information to, or any other information from, my financial institution(s), creditor(s), county commissioners and their agents for my county of residence and Faulkton Area Medical Center.
Signature _____ Date _____
Social Security Number_____

Spouse's Signature _____ Date _____
Spouse's Social Security Number_____

Privacy Act Credit Information and Release Authorization Form

Under the authority of Executive Order #9397, the Privacy Act of 1974, Title 5 Paragraph 552a, USCA, information regarding your Social Security number is requested in order to confirm your identification. The information provided by you will become a permanent part of your Credit Information Release Authorization/Audit Trail System. You are not required to provide this information, however, failure to do so will result in our inability to receive confirmation of your employment, pay and tenure, when agencies request such confirmation.
This is to certify that I, _____ authorize my Personnel Department or Immediate Supervisor to release information confirming my employment, pay and forwarding addresses to Faulkton Area Medical Center, Faulkton, SD. Such information may be released orally, pursuant to an oral request. This authorization is effective immediately.

Signature_____

Date _____ Social Security # _____

Signature_____

Date _____ Social Security # _____

Date of Disability Determination_____

Employer's Name _____

Employer's Address_____

_____

_____

Employer's Telephone Number_____