

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

FINANCIAL STATEMENT FOR \_\_\_\_\_

Age: \_\_\_\_\_ Spouse's Name \_\_\_\_\_

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	_____	_____
Home: # Rooms _____		Public Assistance	_____	_____
Purchase Price _____		Unemployment	_____	_____
Improvements _____		Workmens Comp.	_____	_____
Est. Value Now _____		Strike Benefits	_____	_____
Other Real Estate _____		Alimony/Child Supp	_____	_____
Other Investments-savings: (list)		Military Allot.	_____	_____
Furniture \$ Appliances _____		Mthly Rental Income	_____	_____
		Other (List)	_____	_____
		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: \_\_\_\_\_

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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 # \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employer's Telephone Number \_\_\_\_\_