



PATIENT FINANCIAL WORKSHEET

Patient Name: _____ Account Number: _____

Person Responsible for paying account: _____ Phone#: _____

Address: _____

Employer: _____

If not employed, last day worked: _____

Spouse's Name: _____

Spouse's Employer: _____

If not employed, last day worked: _____

Number of Dependents in Household (do not include yourself): _____

1a Available Income:
Monthly Salary/Pension _____
Monthly SSI/VA _____
Monthly Unemployment _____
Other _____
Total Income _____

1b Expenses:
Rent/Mortgage _____ Electric _____
Gas (Home) _____ Telephone _____
Water _____ Car Payments _____
Credit Cards _____ Insurance (Auto) _____
Insurance (Health) _____ Insurance (Home) _____
Total Expenses _____

1c Copies of the following must be returned to the Hospital with this Worksheet (if applicable):

1. Most recent income Tax Return
(If unable to supply most recent tax year's return then W2 Forms and/or Forms 1099)
2. Last two pay stubs received from current employer and last pay stub received from all other jobs worked this year
3. Unemployment Compensation letter if unemployed
4. Social Security Income and/or Retirement Income verification
5. Most recent bank statement received for all checking/savings accounts

1d Assets:

Bank Accounts	_____
Bonds	_____
Stocks	_____
CD's	_____
Mutual Funds	_____
Rental/Other Property	_____
<i>Total Assets</i>	_____

The Hospital, in its sole discretion, may request additional information as set forth in the Hospital's Financial Assistance Policy.

This Worksheet must be returned no later than thirty (30) days following your receipt of this Worksheet.

Applications for Financial Assistance that are returned to the Hospital without copies of the items listed in Section 1c above cannot be considered.

I attest that the above information is correct.

Signature

Date

I attest that the above information is correct and that the Patient/Guarantor is unemployed and cannot provide employment documentation.

Signature

Date