



FINANCIAL EVALUATION

ACCOUNT NUMBER(S): _____

PATIENT: _____ SS#: _____ Dependents/Adults
In Household: _____

GUARANTOR: _____ SS#: _____
SPOUSE: _____ SS#: _____ Yearly Gross Income
\$ _____

ADDRESS: _____ PHONE# _____

Have you applied for Medicaid, Medically Needy, or other State/Federal Assistance? Yes No.

Are you pregnant? Yes No Do you have minor children? Yes No. Are you disabled or receiving SSDI? Yes No.

Does applicant qualify for Medicaid? Yes No. Does applicant qualify for any other state or Federal Programs Yes No

List programs applicant may qualify for: _____ Patient / Applicant **does not** qualify for Medicaid: _____

Dependents/Adults In Household For additional dependents please add

	Name	Relationship	Age	Date of Birth
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Place of Employment: (Guarantor) _____ Phone: _____

Place of Employment: (Spouse) _____ Phone: _____

Monthly Income

Are you self-employed or own your own business? Yes No **If yes please provide financial statements with application.**

Employment: Guarantor: _____	Child Support _____
Employment _____	Rentals _____
Social Security _____	Real Estate _____
Veteran Administration _____	Other _____
Unemployment _____	Work Comp _____
	Total Monthly Income: _____

Monthly Expenses

Rent _____	1 st Car Payment _____
1 st Mortgage _____	2 nd Car Payment _____
2 nd Mortgage _____	Car insurance _____
Electric Gas _____	Water _____
Child Care _____	Telephone _____
Health Insurance _____	Cable T.V. _____
Medical Bills _____	Internet _____
Credit Cards _____	Food _____

Adjusted Monthly Income: _____

Total Monthly Expenses: _____

LIQUID ASSETS

Name Of Bank/Credit Union	_____	Balances	_____
Savings Account	_____	Balances	_____
Checking Account	_____	Balances	_____
Other	_____	Balances	_____
Other	_____	Balances	_____

TOTAL LIQUID ASSETS \$ _____

NON-LIQUID ASSETS

Real Estate	_____	Stocks	_____
2 nd Automobile	_____	Bonds	_____
Boat	_____	CD's	_____
Life Insurance	_____	Other	_____
Loans	_____	Other	_____
** Value of 1 st Automobile	_____	** Value of Homestead	_____

TOTAL NON-LIQUID ASSETS \$ _____

TOTAL ASSETS \$ _____

Letter of Support: By Signing this letter of support this in no way obligates you for the patient's bills.

I, _____ provide room and board and or financial assistance for _____
_____. Signed by, _____

Relationship _____, Date _____

***** **Proof Of Income Must Accompany This Application** *****

I _____ certify that my family income for the past 12 months has been \$ _____

and can be verified by contacting the following employer(s):

Company: _____ Phone: _____

Company: _____ Phone: _____

I hereby authorize Parrish Medical Center to verify the information on this application by whatever means necessary. I further understand that this could mean contacting my employer, my bank or running a credit report.

I understand that to be eligible for this program, I must be willing to apply for any and all State and Federal programs or private sources available to pay this bill. I also understand that this application can be re-evaluated at any time if Parrish Medical Center finds it necessary.

I further certify the foregoing information given by me on this application is true and accurate in accordance with 817.50 of public law 79-725, providing information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree. Should any changes occur as to the information given by me on the application, I agree to promptly notify Parrish Medical Center.

SIGNATURE OF PATIENT AND/OR GUARANTOR: _____ Date: _____

SPOUSE SIGNATURE: _____ Date: _____

WITNESSED BY: _____ Date: _____