



FINANCIAL STATEMENT

ASSISTANCE REQUESTED:

Please check on of the options below:

- I am requesting monthly payments.
- I am requesting Patient Financial Assistance.

Responsible Party

Name _____

Date of Birth _____

Age _____ Phone Number _____

Social Security Number _____

Spouse

Name _____

Date of Birth _____

Age _____ Phone Number _____

Social Security Number _____

Present Address

Street _____

City _____

State _____ Zip Code _____

No years _____ Own Rent

Former address if less than two years at present address.

Street _____

City _____

State _____ Zip Code _____

No years _____ Own Rent

Present Address

Street _____

City _____

State _____ Zip Code _____

No years _____ Own Rent

Former address if less than two years at present address.

Street _____

City _____

State _____ Zip Code _____

No years _____ Own Rent

Marital Status: Married Separated Single (Includes single, divorced, widow or widower)

Number of legal dependents _____ Ages of legal dependents _____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION LISTED ON THIS FINANCIAL STATEMENT GIVEN TO FAITH REGIONAL HEALTH SERVICES IS TRUE AND CORRECT AND I HEREBY AUTHORIZE FAITH REGIONAL HEALTH SERVICES OR THEIR AGENT TO VERIFY ANY INFORMATION GIVEN ON THIS FORM.

Responsible Party Signature

Spouses Signature

Date

Responsible Party

Name of Employer _____
Address of Employer _____
Phone Number of Employer () _____
Years Employed at Current Employer _____
Position/Title _____
Type of Business _____
Business Telephone Number () _____
Supervisor _____

Spouse

Name of Employer _____
Address of Employer _____
Phone Number of Employer () _____
Years Employed at Current Employer _____
Position/Title _____
Type of Business _____
Business Telephone Number () _____
Supervisor _____

The next section will ask about your income and assets. You are required to supply the previous three month's worth of pay stubs. If you do not have your pay stubs, you may have your employer write a statement telling us your gross income for the preceding three months. That statement must be on the employer's letterhead. You may also provide the last year's income tax return if you are self employed.

MONTHLY INCOME/ASSETS

ITEM	SELF	SPOUSE	TOTAL
Gross Income	\$ _____	\$ _____	\$ _____
Workers Comp	\$ _____	\$ _____	\$ _____
Interest	\$ _____	\$ _____	\$ _____
Dividends/Stocks & Bonds	\$ _____	\$ _____	\$ _____
Child Support Received	\$ _____	\$ _____	\$ _____
Alimony Received	\$ _____	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____	\$ _____
Military	\$ _____	\$ _____	\$ _____
Unemployment	\$ _____	\$ _____	\$ _____
Disability/SSI	\$ _____	\$ _____	\$ _____
Food Stamps	\$ _____	\$ _____	\$ _____
Other Income	\$ _____	\$ _____	\$ _____
Cash (Checking and Savings)	\$ _____	\$ _____	\$ _____

<p>FOR OFFICE USE ONLY: Three previous month's gross income times four (4) _____</p> <p>One month's gross income times twelve (12) _____</p>

This section describes your monthly expenses/liabilities. Please complete accurately.

MONTHLY EXPENSES/LIABILITIES

ITEM		ITEM	
Alimony Paid	\$ _____	Rent Payment	\$ _____
Auto: Monthly gas paid	\$ _____	Mortgage Payment	\$ _____
Auto: Monthly oil	\$ _____	Value of Real Estate	\$ _____
Cable TV	\$ _____	Mortgage Balance Due	\$ _____
Child Care Expenses	\$ _____	Auto Payment	\$ _____
Child Support Paid	\$ _____	Balance Remaining	\$ _____
Charity Contributions	\$ _____	List year, make, model	_____
Clothing/Shoes	\$ _____	Auto Payment	\$ _____
Entertainment	\$ _____	Balance Remaining	\$ _____
Food and Paper Products	\$ _____	List year, make, model	_____
Garbage Pick up	\$ _____	Credit Card (Name)	_____
Insurance: Auto	\$ _____	Monthly payment	\$ _____
Insurance: Renters	\$ _____	Credit Card Balance	\$ _____
Insurance: Home Owners	\$ _____	Credit Card (Name)	_____
Insurance: Health	\$ _____	Monthly payment	\$ _____
Insurance: Life	\$ _____	Credit Card Balance	\$ _____
Lot Rent (Mobile Homes)	\$ _____	Credit Card (Name)	_____
School expenses	\$ _____	Monthly payment	\$ _____
Telephone: Base Charges	\$ _____	Credit Card Balance	\$ _____
Utilities: Gas	\$ _____	Other loan	\$ _____
Utilities: Electric	\$ _____	Other loan balance	\$ _____
Utilities: Water	\$ _____	Other loan	\$ _____
Newspaper:	\$ _____	Other loan balance	\$ _____
Medications	\$ _____	Physician Payments	\$ _____
Hospital Bill (Total Due)	\$ _____	Boat/Motorcycle/ATV/RV	\$ _____
Hospital Bill (Monthly Paid)	\$ _____	Other	\$ _____

Office Use Only: List the total monthly expenses/liabilities: \$ _____