

Confidential Financial Evaluation

Account #: _____

Last Name _____ First _____ Middle Initial _____

Date of Birth _____ Social Security # _____ Telephone #: _____

Address: _____ How long? _____

City _____ State _____ Zip Code _____

List Spouse and Children living in household:			Monthly SSI/SSD Income
Last Name	First Name	Date of Birth	Received for Each Person

Have you qualified for financial assistance at Blount Memorial in the last 12 months? _____

Have you filed or are you considering a lawsuit that may include your hospital bill? _____

Employer _____	Date of Hire _____	Telephone # _____
Hourly Wage _____	Hours worked per week _____	Monthly Income _____
Spouse Employer _____	Date of Hire _____	Telephone# _____
Hourly Wage _____	Hours worked per week _____	Monthly Income _____

If you are self employed, please complete the following:

Self Employment Name of Person	Type of Business or Profession including Product or Service	Total Receipts or Sales	Average Monthly Profit

Copy of Quarterly IRS 1040 forms and previous year Schedule C Profit or Loss from Business must be provided

Are you an adult living with your parent/guardian or family member? _____
Does your parent/guardian claim you as an IRS dependent? _____ If yes, please provide the following:
Father's Hourly Wage _____ Hours worked per week _____ Annual Income _____
Mother's Hourly Wage _____ Hours worked per week _____ Annual Income _____

Other Income (please provide monthly amount received from any of these)

Food Stamps	SSI / SSD	Other Disability	Unemployment
\$ _____	\$ _____	\$ _____	\$ _____
Child Support	Alimony	Retirement / Pensions	
\$ _____	\$ _____	\$ _____	

Who pays or assists you in paying for your household expenses: _____

Account #: _____

Page Two (continued)

Please provide an estimated balance for the following:

Regular Checking	Regular Savings	Stocks	Money Market
\$ _____	\$ _____	\$ _____	\$ _____
CDs	Bonds	401K / IRA / TSA / Retirement Savings	
\$ _____	\$ _____	\$ _____	

<i>Listing of Assets</i>	<i>Property Assessment Value</i>	<i>Outstanding Debt/Liability</i>	<i>Net Value (Market Value less Debt)</i>
Primary Residence (Own or Purchasing) Number of Acres _____	\$ _____	\$ _____	\$ _____
Are you Renting? Yes _____ No _____			
Automobiles: Auto 1 Model/Year _____ Auto 2 Model/Year _____	\$ _____	\$ _____	\$ _____
Other Property / Business / Rental Name of Properties _____ Location/Address: _____ _____	\$ _____	\$ _____	\$ _____
Farm and/or Business Equipment Description of assets: _____ _____	\$ _____	\$ _____	\$ _____

To the best of my knowledge the following information is factual. I acknowledge that in accordance with Statue 817.50, I understand that providing false information to defraud a hospital for purposes of obtaining goods or services is a misdemeanor in the second degree. I hereby authorize Blount Memorial Hospital to verify any of the above information.

Patient/Guarantor Signature _____ Date _____

Signature of Witness _____ Date _____

Submit Verification of Income and Assets with this application within 14 Business Days