Blount Memorial Hospital

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: Last Name	First Name	Date of Birth	Social Security Number	Monthly SSI/SSD Income 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**	
$	$	$	

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

ASSETS

Please provide an estimated balance for the following:

Regular Checking	**Regular Savings**	**Stocks / Bonds**	**Money Market**
$	$	$	$
CDs	**HSA / HRA / FLEX Spending Acct**	**401K / IRA / TSA / Retirement Savings**	
$	$	$	

Property and Equipment	***Property Assessment Value***	***Outstanding Debt/ Liability***	***Net Value (Market Value less Debt)***
Primary Residence (Own or Purchasing) Number of Acres _____	$	$	$
Other Property / Business / Rental Name of Properties _____ Location/Address: _____ _____	$	$	$

Monthly Household Expense	**Amount**	**Balance Overdue**		**Other Monthly Expense (Name and type of debt)**	**Amount**	**Balance Owed**
Rent/Mortgage				Utilities		
Food				Cell Phone / Other		
Automobile				Motor vehicle Insurance		
Credit Cards / Other				(do not include Blount Memorial) **Medical Bills**		
Total:				**Total:**		

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 _____

Spouse or Witness Signature _____ Date _____

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

920-6 Assistance Request (Revised 09-2017)