REQUEST FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE PROGRAM: FINANCIAL STATEMENT

I herby request that Parkside Psychiatric Hospital and Clinic evaluates the following financial information in regards to my possible eligibility for a Financial Assistance Program for hospital or clinic services (non-professional fees) through the hospital. I understand that the information I provide concerning the annual income and size of my household is subject to verification by the hospital. I also understand that if any portion of the information I have provided is determined to be falsified, I will be responsible for all medical expenses incurred at this hospital.

Demographic Information:

Patient Name ______________________________________ Account Number ________ DOB ____________________
Address ______________________________ City ________________ State _____ Zip ____________________
Phone Number(s) Cell: ________________ Work: _______________ SSN _________________ DL# _________

Employment Information

Occupation: ____
Employer _____________________________ Address: ______________________ Phone No. ________________

Family Size Information

Total Number in Household: ________ **(Number of individuals for whom you are financially responsible)**

Name	Birth date	Relationship

Monthly Family Income

Patient Gross wages $__________
Spouse or Significant Gross Wages $______________
Child Support $______________
$______________
Dividends, interest $______________
Alimony $______________
Other: _______________________________________ $______________
(specify) ____

Worker's Comp $ _________________
Attorney/carrier name __________________
Address ______________________________
Phone _______________________________
Social Security type and amount(s)
(1) _______________________ $ _________
(2) _______________________ $ _________

Deductions from pay (attach most recent pay stub(s) or income tax form other than taxes): $

Check Stub	Fed/State tax	Social Security	Union	Insurance	Pension	Other
Patient's						
Spouse's						
Other						

Cash on hand/money in the bank, savings, etc. $________________ **Provide copies of bank statements**

Monthly Expenses

Automobiles	Car "A"	Car "B"	Car "C"
Monthly Payment			

Rent/mortgage $ ______________ Utilities $ ______________ Food $ ______________
Telephone $ ______________ Cell phone $ ______________ Cable $ ______________
Gas $ ______________ Insurance $ ______________ Medical $ ______________

Prescription cost per month $ __________

Hospital/doctor/dentist $ __________ Names ______________________________

Credit cards $ __________ Names ______________________________

Installment debts $ __________ Creditor's name(s) ______________________________

Other debts $ __________ Names ______________________________

Comments: ______________________________

I affirm that the above information is true and correct to the best of my knowledge.

Applicant's signature **Date**

Hospital Representative **Date**

For hospital use only:

Determination of Eligibility

Total monthly income $ ______________ Total monthly bills (excluding non-essentials) $ ______________
Applicant is eligible ☐ Yes ☐ No
Applicant will need complete to complete an installment agreement ☐ Yes ☐ No
Applicant's current balance $ ______________ Current balance is from ☐ IP or ☐ OP
Patient's insurance
Applicant's discounted lump sum $ ____________

Denied/Explain: ______________________________

Business Office Director Date

CFO (= to or greater than $7,500) Date

CEO (= to or greater than $10,000) Date