

# Financial Evaluation Form



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
 Permanent Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 State: \_\_\_\_\_ Hm Phone: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

**Mailing Address if Different:**

Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Employer Ph: \_\_\_\_\_  
 Employer Address \_\_\_\_\_

- 1 Have you applied for financial aid or completed this form in the last 90 days? Yes No
- 2 Do you currently have any type of health insurance? Yes No
- 3 Was your hospital visit a result of an accident at work? Yes No
- 4 Was your hospital visit a result of a auto accident? Yes No
- 5 Is your primary residence outside of the US? Yes No

If you answered YES to ANY of the questions above, STOP this is not the correct form. Please contact the business office to discuss your account.

Please list all family members (including yourself). Family members are persons related by birth, marriage, or adoption living together in the home along with the patient. Also included are children who are full time student in an accredited college. Income includes gross (pretax) wages, rental income, unemployment compensation, social security benefits, public assistance, etc. (Income also includes rent or living expenses exchanged for services provided.)

Family Member (Name)	Relationship to Patient	Age	Source Of Income or Employer Name	Last Three Paystubs	Income for 12 months Tax Return
Total Family Members			Total Income		

\*\*W2 Forms and State assistance documents may also be used to record income above.  
 If you reported \$ 0.00 income above, please have the Support Statement below completed by the person(s) helping to support you and/or your family. Your signature is also required on this application.

Your application will not be considered unless you bring copies of the following documents to support the income information above

- Pay stubs for the last three months.
- Income Tax return for the previous year.
- W2 Form.
- State Assistance Document.

I certify that the information provided is true and accurate to the best of my knowledge

Signature of Patient, or Person Authorized to Sign for Patient \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Date \_\_\_\_\_

For Hospital Use Only  
 Account Number \_\_\_\_\_ Date of Service: \_\_\_\_\_  
 BMH Facility \_\_\_\_\_

▼ Addressograph/Patient Label ▼