# INSTRUCTIONS FOR COMPLETING THIS FORM

In order for a patient to be eligible for special financial consideration, this form should be completed and the requested documentation attached, and the form returned to the **Methodist McKinney Hospital.** The information will be verified and proper determination will be made in a timely manner. Please provide the following documentation to the facility:

* This form, completed and signed
* Copies of signed Federal Income Tax Return for previous year
* Copies of payroll check stubs for the previous 2 months
* Copies of recent utility bills, rent/mortgage receipt, medical bills, auto loan receipts, bank statements, alimony/child support receipts, government assistance receipts, other income/investment statements (e.g. 401K statement)

## RESPONSIBLE PARTY INFORMATION

Responsible Party Marital Status

Address State Zip

SSN Birth Date Phone

Employer Position Phone Hire Date

Address City State Zip

Spouse Birth Date SSN

Spouse’s Employer Position Phone Hire Date

Number of children in the house Ages

## MONTHLY INCOME INFORMATION

Please provide documentation of income sources – W-2 forms, income tax statements, check stubs, or check statements. A financial statement may be required if you are self-employed.

**Responsible Party Spouse**

Wages before deductions

Alimony/Child support

Disability/worker’s comp

Pension

Social Security Income

Dividends/Interest Income

Rental Income

Estate Trust Income

Welfare/Public assistance

Food Stamps

Other (please list)

Less State/Federal Taxes

Less any other deductions

**Monthly Income Total $ $**

# FINANCIAL INFORMATION

### ASSETS VALUE VALUE

Cash/Checking Investments

Savings Life Insurance

Stocks and Bonds Other

**ALL REAL PROPERTY AND VEHICLES**

**VALUE BALANCE MONTHLY PAYMENT**

Residence rent / own (circle one)

Other property

Vehicle #1 Make Model Year

Vehicle #2 Make Model Year

Vehicle #3 Make Model Year

**MEDICAL EXPENSES**

**Medical Provider’s Name BALANCE INS WILL PAY MONTHLY PAYMENT**

**LIST ALL OTHER CREDITORS**

(Charge cards, mail order, etc. - - attach separate sheet if necessary)

**CREDITOR’S NAME TYPE LOAN BALANCE MONTHLY PAYMENT**

**Appliance or furniture rental:**

**Have you ever filed bankruptcy?** Yes No Give date

# OTHER MONTHLY EXPENSES

### EXPENSE MONTHLY PAYMENT EXPENSE MONTHLY PAYMENT

Food Auto Insurance

Phone Cable TV

Electric/Gas/Water/Sewer Health Insurance

Contributions Recreation

Other (List) Other (List)

***FOR OFFICE USE ONLY…***

### MONTHLY FINANCIAL SUMMARY

**Total Income:**

**Subtotals:**

**Real property**

**Vehicles $**

### Monthly Medical

### Expenses $

**Creditors**

**Credit $**

**Other Monthly**

**Expenses $**

**Total Expenses:**

# PATIENT CONDITIONS AND COMMENTS

Please answer the following questions – attach additional pages if necessary

Have you applied for Medicaid and been denied or found to be ineligible? Yes No (circle one)

Have you asked for assistance from your family? Yes No (circle one)

Have you asked for assistance from your clergy or church? Yes No (circle one)

How much are you able to pay each month?

**COMMENTS:**

I hereby state that the information I have provided is true and complete. I authorize **Methodist McKinney Hospital** to verify this information, including requesting a credit bureau report. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration and I will be liable for payment of any and all charges incurred for the services rendered.

**X Date:**

### Responsible Party Signature