FINANCIAL STATEMENT **Date:**_____

The information being requested is to determine if you qualify for financial assistance or a payment plan to satisfy your account(s) with Roper St. Francis Healthcare. All information provided is strictly confidential for your protection.
This application must be completed in its entirety in order to be processed. The account balance(s) will remain billable to the guarantor &/or responsibility party until a final outcome has been reached.

PATIENT INFORMATION

Name:	Home Telephone:
Street Address:	Social Security #:
Street Address:	Date of Birth:
City:	State: Zip:

Circle one: Single Married Common Law Legally Separated Divorced Widowed Life Partner

Spouse's Name:_____ Spouse's Social Security #:_____

GUARANTOR / RESPONSIBLE PARTY INCOME INFORMATION

Name of Employer:	Employer Phone Number:
Address of Employer:	Social Security #:
City/State/Zip:	Date of Hire:

Please Circle One

Total Household **Gross** Income:	$_____	Proof of Income must be submitted	Per Week	Every 2 Weeks	Per Month	A Year
Other Household Income:	$_____	Proof of Income must be submitted	Per Week	Every 2 Weeks	Per Month	A Year

(such as Part Time Job, Alimony, Family/Outside Contributions, Trusts, Annuities, Pensions, Retirement Benefits, Disability Income, Unemployment Benefits, Student Loan Disbursements, unreported income, etc.)
If receiving any of the above, proof of income must be attached in order to process your application.

If you claim your income as $0.00, you must provide information regarding your living situation and/or means of support: _____
_____

Are you a U.S. Citizen or visiting the U.S. legally? Yes_____ **or No**_____

Total Number of Exemptions claimed on Federal Tax Return: _____

Do you have any Health Insurance coverage not previously filed? (circle one) Yes or No
If yes, name of Insurance Company, Address, Phone Number and Policy Number: _____
_____

Have you or your spouse ever applied for Medicaid or Disability Benefits? (circle one) Yes or No
Please explain outcome: _____

Is insurance, attorney, or any other 3rd party payment involved for any remaining Roper St. Francis Healthcare account balances? (circle one) Yes or No
Please provide details: _____
_____

PLEASE TURN OVER

Debts	Creditor Name and Address	Balance	Actual Monthly Payments/Expenses
Mortgage/Rent			
Second Mortgage			
Automobile Loan			
Automobile Loan			
Annual Property Taxes			

Debts	Actual Monthly Payments/Expenses
Credit Card Monthly Payments	
Utilities (Power,Gas,Phone,Cable)	
Groceries	
Prescription, Non-Prescription Drugs	
Dependent Care or Nursing Home Care	
Tuition	
Health Insurance Premiums	
Auto Insurance Premiums	

PLEASE DESCRIBE ANY SPECIAL CIRCUMSTANCES, IN addition TO THE PREVIOUS INFORMATION, THAT WOULD HELP US IN QUALIFYING YOU FOR FINANCIAL ASSISTANCE. PLEASE INCLUDE ANY SIGNIFICANT MONTHLY EXPENSES THAT MAY PREVENT YOU FROM PAYING THIS DEBT:

_____

_____

_____

_____

I ATTEST THAT THIS FINANCIAL STATEMENT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ROPER ST. FRANCIS HEALTHCARE TO VERIFY MY EMPLOYMENT, DEBTS AND ASSETS AND I UNDERSTAND THAT THE PATIENT'S AND/OR GUARANTOR'S CREDIT REPORT MAY BE REVIEWED. I UNDERSTAND THAT FALSIFYING APPLICATION INFORMATION MAY RESULT IN A DENIAL OF FINANCIAL ASSISTANCE. I UNDERSTAND THAT EACH CALENDAR YEAR I MUST RE-QUALIFY FOR ASSISTANCE.

_____ _____

Signature of Responsible Party (Required) **Date**