

# Black River Medical Center

## FINANCIAL ASSISTANCE FORM

### 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 Hospital. The information will be verified and proper determination will be made in a timely manner. Please provide the following documentation to the Hospital:

- Medicaid Denial Letter
- This form, completed and signed
- Copies of signed Federal Income Tax Return for previous year
- Copies of payroll check stubs for the previous two (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, and/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	_____	_____
<b>Monthly Income Total</b>	<b>\$</b> _____	<b>\$</b> _____

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### 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 <u>Make</u> <u>Model</u> <u>Year</u>	_____	_____	_____
Vehicle #2 <u>Make</u> <u>Model</u> <u>Year</u>	_____	_____	_____
Vehicle #3 <u>Make</u> <u>Model</u> <u>Year</u>	_____	_____	_____

### 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

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**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 the 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**  
**Responsible Party Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_