Financial Information Report **Doctors' Memorial Hospital (Revision 11/1/15)**

Admit Date: _____ Account Number/s: _____ _____ _____
Patient: _____ Phone #: _____
Address: _____
Mailing Address: _____ _____
City: _____ State: ____ _____ Zip: _____ _____
Date of Birth: _____ SS #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

HOUSEHOLD COMPOSITION (LIST PERSON/S LIVING AT HOME)

Name	Sex–M / F	Date of Birth	Relationship
Please list additional names on the back of this page.			

ANNUAL INCOME INFORMATION (LIST INCOME FROM THE PREVIOUS 12 MONTHS)

Employer (present): _____ Length of Employment: _____ Phone #: _____
Gross Wages: _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Salary ☐ Yearly Number of hours: _____
Do you own the business? ☐ Yes or ☐ No If yes, please supply personal & business Tax Returns.
Employer (past): _____ Length of Employment: _____
Gross Wages: _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Salary ☐ Yearly Number of hours: _____
Spouse Employer: _____ Length of Employment: _____ SS # _____
Gross Wages: _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Salary ☐ Yearly Number of hours: _____
Retirement Benefits? ☐ Yes ☐ No Amount: $ _____
Social Security Benefits? ☐ Yes ☐ No Amount: $ _____
Veteran Benefits? ☐ Yes ☐ No Amount: $ _____
IRA's? ☐ Yes ☐ No Amount: $ _____
Unemployment Benefits? ☐ Yes ☐ No Amount: $ _____
Any other household income? ☐ Yes ☐ No Amount: $ _____

If you are claiming no income please tell us who is supporting you; name/phone#:
_____
_____
_____

ASSET INFORMATION

Name of bank: _____ Checking $ _____ Savings $_____
Stocks: ☐ Yes or ☐ No $ _____ Bonds: ☐ Yes or ☐ No $ _____ CD's: ☐ Yes or ☐ No $_____
Home: Own-☐ Yes or ☐ No Rent - ☐ Yes or ☐ No Buying - ☐ Yes or ☐ No What is the monthly payment? $ _____
Do your own other property: ☐ Yes or ☐ No If yes, what is the location: _____
Automobile 1 Year _____ Make: _____ Balance or monthly payment $ _____
Automobile 2 Year _____ Make: _____ Balance or monthly payment $ _____

MEDICAID QUESTIONNAIRE

Have you applied for Medicaid? ☐ Yes or ☐ No Date you applied: _____ Where: _____
Do you have other insurance? ☐ Yes or ☐ No Ins Name & Policy # _____
Comments: _____

Combined gross income for the past 12 (twelve) months has been $ _____ and there are _____ number of people in my family. The income information can be verified by calling the above employers. Additionally, I understand that in accordance with Florida Statues 817.50, providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor in the second degree. Further, the undersigned hereby consents to the hospital's inquiries into his/her credit history in conformity with the legitimate business needs and applicable laws, rules and regulations. In the event that assets or a payment become available, Doctor's Memorial Hospital reserves the right to reverse the original adjustment.

I hereby certify the above information to be true and correct.

_____ _____
Patient/Guarantors Signature Date

_____ _____
Spouse Signature Date

_____ _____
Witness Signature Date

DMH Financial Counselor Completes This Section.

Date Application Approved / Denied: _____
Employee: _____
Effective Date: _____
Expiration Date: _____ Collect Code: _____
_____
Reason for Denial: _____